STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Hesselberg Chiropractic
Petitioner **File No. 21-1029**

v

Citizens Insurance Company of the Midwest
Respondent

Issued and entered
this 18th day of June 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 29, 2021, Hesselberg Chiropractic (Petitioner) filed with the Director of the Department of Insurance and Financial Services (Department) a request for appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for appeal concerns a bill denied by Citizens Insurance Company of the Midwest (Respondent) for the Petitioner's chiropractic treatments rendered to the injured person on April 8, 2021.

The Department accepted the request for appeal on April 29, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on May 3, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on May 24, 2021.

The Department assigned an independent review organization (IRO) to review the issues in this appeal and provide a report and recommendation to the Department. The IRO submitted its report to the Department on June 2, 2021.

The Petitioner's appeal is made under R 500.65, which allows a provider to appeal to the Department from a determination made by an insurer. The Petitioner seeks payment in the full amount billed to the Respondent.

II. FACTUAL BACKGROUND

This appeal concerns the denial of a bill by the Respondent for chiropractic services rendered on April 8, 2021. The Respondent issued a determination letter to the Petitioner dated April 28, 2021. The

Respondent did not request a written explanation from the Petitioner regarding the medical necessity or indication for the treatment rendered to the injured person relevant to this appeal.

With its appeal request, the Petitioner submitted supporting documentation demonstrating the following diagnoses for the dates of service at issue: segmental and somatic dysfunctions of the lumbar, thoracic, cervical, sacral, and pelvic regions; low back pain; thoracic spine pain; cervicalgia; and disorder of ligament, unspecified site. The treatment included spinal manipulation, mechanical traction, and therapeutic exercises. The CPT codes billed were 98942, 97012, and 97110, respectively.

In its determination letter issued April 28, 2021, the Respondent denied payment for CPT codes 98942, 97012, and 97110. In its reply to the appeal, the Respondent issued a response dated May 18, 2021, denying payment for the April 8, 2021 service as not medically necessary.

Petitioner's Argument:

In its appeal, the Petitioner argues that the care provided to the injured person was medically necessary for treatment of low back pain, upper back pain, and cervical pain.

Respondent's Argument:

In its reply to the appeal, the Respondent explained that it denied the billed services as not medically necessary after reviewing the medical documentation provided by Petitioner.

III. Analysis

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal is a matter of medical necessity and overutilization of services.

In support of its position, the Petitioner argues that the injured person had slowly been improving since treatment began December 28, 2020. In the medical record, the Petitioner noted that the injured person's pain level had decreased from 6/10 to 4/10 on the pain scale and that the injured person was expected to reach maximum medical improvement by the end of the treatment plan. No initial examination or subsequent re-examination records were included with the supporting documentation.

The Respondent's April 28, 2021 determination A did not recommend reimbursement for the chiropractic treatments rendered on the date of service at issue based on a review of the documentation submitted and in accordance with national and regional standards of care. The Respondent's determination referenced the following standards of care in support of its conclusion:

> Patients with low back or neck pain resulting from a motor vehicle accident should show statistically significant improvements in pain level, function and medication use. (Schofferman J., Wasserman S.). The current evidence suggests that exercise alone or in combination with education is effective for preventing low back pain. (Daniel Steffens, PhD 1,2; Chris G. Maher, PhD1; Leani S. M. Pereira, PhD2; et al.)

In its May 24, 2021 reply, the Respondent stated that the submitted documentation did not substantiate the treatment rendered as in accordance with generally accepted medical standards.

The Director assigned an IRO to review the case file. In its June 2, 2021 report, the IRO reviewer recommended that the Department uphold the insurer's determination. The IRO reviewer concluded that the treatment provided to the injured person on April 8, 2021 was not medically necessary.

The IRO reviewer is board-certified in chiropractic medicine. The IRO reviewer referenced R 500.61(i), in its report, which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations. The IRO reviewer relied on peer-reviewed journal articles supporting current evidence-based practice guidelines, including current Official Disability Guidelines (ODG).

In its report, the IRO reviewer stated that treatment codes 98942, 97012, and 97110 were properly documented in the medical record for the date of service at issue. The IRO reviewer explained:

> Additionally...the treating provider documented the units of time the treatment modality was applied, the medical rationale for the application of the treatment modality, and the therapeutic exercises performed.

However, although the treatment codes were appropriately documented in the medical record as noted in its report, the IRO reviewer opined that the treatment rendered was not medically necessary in accordance with medically accepted standards as defined by R 500.61(i). The IRO reviewer explained in its report that the treatment did not align with ODG guidelines. The guidelines support a trial of 6 visits over the course of 2 to 3 weeks, with evidence of objective functional improvement, and up to 18 visits of chiropractic treatment over a total of 6 to 8 weeks for the diagnosed conditions. The IRO reviewer also noted that the Petitioner submitted limited documentation for review.

The Petitioner's supporting documentation stated that treatment began December 28, 2020 and that the injured person had slowly been improving since the start of care. However, the IRO reviewer opined that the submitted documentation was inadequate to establish the frequency of treatment rendered and to identify objective improvements made in the injured person's condition, as supported by evidence-based practice guidelines.

Specifically, the IRO reviewer explained:

> There is no indication, based on the records provided, how many sessions of chiropractic treatment rendered on 4/8/2021 falls outside the recommended treatment duration of 6-8 weeks. Without documentation to support complicating factors and/or comorbidities, treatment beyond the recommended treatment frequency and duration protocols cannot be supported. Additionally, elective/maintenance care is not supported as medically necessary.

Consistent with the above rationale, the IRO reviewer noted that the treatment rendered was overutilized in duration "pursuant to the generally accepted evidence-based treatment guidelines." The IRO reviewer specifically stated:

> While referenced evidence-based guidelines provide allowances of 1-2 visits every 4-6 months for reoccurrence/flair ups, the limited documentation did not establish this to be the case for the [injured person].

The IRO reviewer stated that the chiropractic treatments provided to the injured person on April 8, 2021 were not medically necessary, were not in accordance with medically accepted standards, as defined by R 500.61(i), and were overutilized in duration compared with such standards. Accordingly, the Director upholds the Respondent's determination dated April 28, 2021.

IV. ORDER

The Director upholds the Respondent's determination dated April 28, 2021.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

Recoverable Signature

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford