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. 21-1037**

v

Citizens Insurance Company of the Midwest
Respondent

Issued and entered
this 30th day of June 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On May 12, 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 bills denied by Citizens Insurance Company of the Midwest (Respondent) for chiropractic treatments rendered by the Petitioner.

The Department accepted the request for appeal on May 13, 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 14, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on June 7, 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 15, 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 payment by the Respondent for chiropractic services rendered on April 14 and 15, 2021. On May 7, 2021, the Respondent issued a determination letter to the Petitioner. 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 May 7, 2021, the Respondent denied payment for CPT codes 98942, 97012, and 97110 for the dates of service at issue as not medically necessary. In its response to the appeal, the Respondent reaffirmed its position that the chiropractic treatments were 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 the 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 argued that the injured person had slowly been improving since treatment began December 28, 2020. In the medical records, the Petitioner noted that the injured person's pain level had decreased from 6 to 4 on a ten-point 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 May 7, 2021 determination 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 reply to the appeal, the Respondent stated that the submitted documentation did not substantiate the treatments rendered as in accordance with generally accepted medical standards.

The Director assigned an IRO to review the case file. In its June 15, 2021 report, the IRO reviewer recommended that the Department uphold the insurer's determination. The IRO reviewer concluded that the treatments provided to the injured person on April 14 and 15, 2021 were not medically necessary and were overutilized in accordance with medically accepted standards.

The IRO reviewer is board-certified in chiropractic medicine. The IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. The IRO reviewer relied on peer-reviewed journal articles supporting current evidence-based practice guidelines as well as Guidelines for Chiropractic Quality Assurance and Practice Parameters.

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 treatments did not meet the criteria for medically accepted standards.

Although the IRO reviewer acknowledged that the injured person remained symptomatic after receiving a sufficient trial of treatment, the IRO reviewer noted that "the file did not reveal any atypical circumstances, pre-existing conditions or co-morbidities that would affect the injured person's recovery process." The IRO reviewer explained that progression of treatment should be indicated by certain clinical markers such as decreased pain, improved range of motion, and decreased orthopedic and neurological findings. Based on the documentation submitted, the IRO reviewer noted that the injured person reported back and neck pain on the dates of service at issue ranging from 3 to 5 on a ten-point pain scale. In addition, the IRO reviewer noted the pain frequency was consistent at 70-80 percent for both dates of service and that the injured person's prognosis was documented as fair. The IRO reviewer opined that after 3 months of care, the provider should focus on improving the injured person's functional capacity, including

performing monthly re-examinations to determine future frequency and length of care. Specifically, the IRO reviewer stated:

> There is no clear rationale for the continuation of passive care over this extended period as the literature indicates that the continued use of passive care and passive modalities beyond the initial acute phase of care (4-8 weeks) does not improve treatment outcomes. At this point there is no reasonable expectation that the same continued chiropractic treatment would provide any further benefits.

The IRO reviewer recommended that the Director uphold the Respondent's determination that the chiropractic treatments provided to the injured person on April 14 and 15, 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.

IV. ORDER

The Director upholds the Respondent's determination dated May 7, 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