STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

A. Rodnick Chiropractic Clinic
Petitioner **File No. 21-1098**

v

Progressive Michigan Insurance Company
Respondent

Issued and entered
this 12th day of August 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 30, 2021, A. Rodnick Chiropractic Clinic (Petitioner) filed with the Director of the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Progressive Michigan Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment and services under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Respondent issued the Petitioner a written notice of the Respondent's determination under R 500.64(1) on April 26, May 6, and May 12, 2021. The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on July 6, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on July 6, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on July 15, 2021.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on July 29, 2021.

II. Factual Background

This appeal concerns the denial of payment for chiropractic treatments rendered on April 8, 13, and 22, 2021. With its appeal request, the Petitioner submitted medical documentation for chiropractic treatments rendered on the dates of service at issue. The Current Procedural Terminology (CPT) codes for the dates of service at issue were 97110, 97112, 97530, 97012, 99072, 97535, and 98942, which refer to therapeutic exercise, neuromuscular reeducation, functional performance activities, mechanical traction, use of supplies or excessive staff time, provider instruction, and chiropractic manipulation, respectively. The Petitioner's submitted medical documentation which identified the following diagnoses for the injured person: cervicobrachial syndrome, unspecified injury of muscles and tendons of the right shoulder rotator cuff, hypoesthesia of skin, weakness, abnormal reflex, other muscle spasm, abnormal posture and segmental and somatic dysfunction of the cervical, thoracic, lumbar, sacral spine and pelvic region.

The Respondent issued an Explanation of Benefits (EOB) with a written request for explanation on April 26, 2021 to the Petitioner for services rendered on April 8, 2021. The written request for explanation asked for information supporting the necessity of treatment and supporting documentation. The Respondent issued additional EOBs with similar requests for written explanation on May 6 and May 12, 2021 for the April 22 and April 13, 2021 dates of service, respectively.

In the EOBs for the dates of service at issue, the Respondent noted that "there is documentation of subjective overall progress as same since previous visit," and that the treatment plan "appears to have extended beyond the maximum of 8 weeks with over 30 sessions noted per history since October 30, 2020." The Respondent further noted in its EOBs that it relied on Official Disability Guidelines (ODG) in addition to the submitted documentation.

In its written explanations, the Petitioner referenced "a number of flaws" it stated were found by professional medical societies in the American College of Occupational and Environmental Medicine (ACOEM) guidelines and explained that the ACOEM guidelines "are not intended to be used for traumatic injuries sustained in motor vehicle accidents." The Petitioner further stated it relies on the 1993 Arthur Croft, D.C. (Croft) guidelines for whiplash injuries which provide 5 grades of injury ranging from minimal to severe along with corresponding recommendations for treatment duration.

Referencing the Croft guidelines, the Petitioner stated in its written explanation:

> The treatment of [the injured person] clearly falls within these well established guidelines, which again are in the only widely published auto injury guidelines and they are based on actual practice patterns of chiropractic physicians, patterns which appear to be consistent throughout North America.

In its reply to the appeal, the Respondent stated that it is "not responsible for payment for the treatment rendered on all three of the dates of service for each and every line item" because the treatment

was rendered on the right shoulder and was outside the scope of chiropractic care. With its reply, the Respondent provided a detailed legal addendum with supporting case law and argued that the treatments were therefore not payable, specifically stating: "[a]s the treatment to the right shoulder did not involve the spinal column, it was outside the scope of chiropractic practice and the expenses incurred are not payable under the No-Fault Act." The Respondent's reply did not address other diagnoses or treatments rendered to areas of the spine on the dates of service at issue.

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.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the dates of service at issue and that the treatments were overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is a board-certified chiropractor with over thirty years of active chiropractic experience . 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, board, and associations. The IRO reviewer relied on the Chiropractic Council on Guidelines and Practice Parameters, ODG and AOEM guidelines. The IRO reviewer also noted in its report that, in addition to being used for worker's compensation and disability, ODG is used in relation to injuries from motor vehicle accidents.

In its report, the IRO reviewer opined that medical necessity was not established for the dates of service at issue as there was no initial history examination or prior daily records included with the Petitioner's submitted documentation to assist in determining the outcome of the injured person's prior care or to identify prior subjective complaints. The IRO stated that the "records are vague" and explained:

> Understanding the response to care is critical…Only three dates of service have been presented. No specific initial history or recheck examinations or prior daily notes have been submitted. This is key information to establish medical necessity, as defined by R 500.61.

The IRO further stated:

> It is only reasonable to provide rehabilitative services if there is the expectation of improvement. Without understanding [of] the prior care or the outcome of the prior care, this reviewer has no expectation of improvement. These concepts are set forth in the Chiropractic Council on Guidelines and Practice Parameters treatment guidelines, which give insight and overview on frequency and duration issues.

The IRO reviewer noted that neuromuscular reeducation was done for the injured person using a total body vibration plate to improve proprioception. However, the IRO reviewer stated that neuromuscular reeducation is a time-dependent code restricted to sitting or standing activities and "thus the upper back and neck therapy are counterintuitive based on the description of the code."

In addition, the IRO reviewer noted that a massage therapy note was submitted with the Petitioner's documentation relating to planned adjustments and exercises, but it lacked specifics. The IRO reviewer stated: "[g]iven the record, this reviewer cannot determine what was performed to what area for what time frame."

As for medically accepted standards, the IRO reviewer opined that the 1993 Arthur Croft management guidelines "are not current and are not evidence-based" as required for chiropractic practice under 1978 PA 368, MCL 333.16401, as of January 1, 2009. The IRO reviewer explained:

> Arthur Croft's 1993 guidelines do not comply with medical necessity standards, as they are not *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*. Arthur Croft's 1993 guidelines are outdated and in my opinion are not valid, as the guidelines were never modified over the years… [Emphasis in original.]

The IRO further stated that without an understanding of the overall frequency and duration of services provided to the injured person, "the question of overutilization of frequency and/or duration of care cannot be addressed."

Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the treatments provided to the injured person on the dates of service at issue were not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determinations dated April 26, May 6, and May 12, 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