STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Mission Chiropractic Family Center, P.C.

Petitioner **File No. 21-1822**

v

Auto Club Group Insurance Company
Respondent

Issued and entered
this 31st day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 8, 2021, Mission Chiropractic Family Center, P.C. (Petitioner) filed with 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 Auto Club Group Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations 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 October 22, 2021 and November 18, 2021. 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 December 8, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on December 10, 2021, and provided the Respondent with a copy of the Petitioner's submitted documents. After requesting and obtaining approval for an extension, Respondent filed a reply to the Petitioner's appeal on January 7, 2022.

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 January 25, 2022.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for chiropractic treatment rendered on 24 dates of service[1] under Current Procedural Terminology (CPT) codes 98940 and 97124, which are described as chiropractic manipulative treatment (CMT), spinal, 1-2 regions; and therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, pertrissage and/or tapotement (stroking, compression, percussion), respectively. With its appeal request, the Petitioner identified the following diagnoses for the injured person in relation to a motor vehicle accident in February 2018: vertebral subluxations of the thoracic and pelvic regions, complicated by foraminal encroachment, disc involvement, and inflammation and edema. The Petitioner documented in its medical record for the dates of service at issue a treatment plan including spinal adjustments at the T6 and pelvis regions. The Petitioner's request for an appeal further stated:

> In my professional opinion [the injured person] may not ever reach pre-accident status, however, [the injured person] maintains that she continues to improve in small increments. [The injured person] still requires weekly chiropractic treatments, has not reached pre-accident status, and should not be released from this auto claim.

In its reply, the Respondent referenced the American College of Occupational and Environmental (ACOEM) recommendations related to chronic pain and noted that manipulation or mobilization of the cervical, thoracic, or lumbar spine is recommended for short-term pain relief or as a component of an active treatment program focusing on active exercises for acute exacerbations. Respondent also referenced the Official Disability Guidelines (ODG) and noted that the injured person received far greater than the recommended 12 visits without any indication of objective improvement.

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 involves a dispute regarding inappropriate treatment and utilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, "there was overutilization of chiropractic care. The records reviewed did not support medical necessity for continued care from 8/6/2021 and ongoing."

The IRO reviewer is a practicing doctor of chiropractic with more than 30 years of clinical experience who is knowledgeable with respect to the medical conditions and type of treatment at issue in

[1] The dates of service at issue in this appeal are August 10, 13, 17, 20, 24, 27, and August 31, 2021; September 3, 7, 10, 14, 17, 21, 24, and 28, 2021; October 1, 5, 8, 12, 15, 19, 26, and 29, 2021; and November 2, 2021.

this appeal. In its report, the IRO reviewer referenced R 500.61(i), 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 the Chiropractic Counseling Guidelines and Practice Parameters, ODG, and ACOEM in reaching its determination. The IRO reviewer opined:

> I could not determine clinically significant subjective and/or objective benefit with the care based on the notes reviewed. The record documents continued subjective complaints of pain without objective benefit. There were no outcome assessments, recheck examinations, or quantifiable information to support continued care. … Continuing chiropractic care without benefit is known to foster dependency and chronicity in patients and should be avoided. The literature is clear that providing care without benefit is not medically necessary.

The IRO reviewer recommended that the Director uphold the Respondent's determination that the treatment provided to the injured person on the dates of service at issue was 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 October 22, and November 18, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

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:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford