

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 111102-001

v

Physicians Health Plan of Mid-Michigan
Respondent

Issued and entered
this 24th day of January 2011
by Ken Ross
Commissioner

ORDER

I
BACKGROUND

On April 1, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On April 5, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Physicians Health Plan of Mid-Michigan (PHP) was notified of the request for external review and furnished the information used in making its final adverse determination.

This case involves medical issues. Therefore, the Commissioner assigned the matter to an independent review organization which submitted its recommendation on April 19, 2010.

II
FACTUAL BACKGROUND

The Petitioner is a member of PHP. Her health care benefits are defined in PHP's certificate of coverage and its medical policy titled, "Panniculectomy/Abdominoplasty Medical Resource Management Benefit Determination Policy."

Petitioner has spinal stenosis for which she has received physical therapy and epidural injections. Over the last year Petitioner has lost 50 pounds. This has resulted in a large amount of excess skin in the abdominal area. Petitioner was referred by her primary care physician, Dr. XXXXX, to plastic surgeon XXXXX, who suggested Petitioner's back problems may be alleviated if she underwent an abdominoplasty.

Petitioner requested coverage for the abdominoplasty. PHP denied the request, asserting that she did not meet its criteria for the requested surgery. The Petitioner appealed the denial through PHP's internal grievance process. PHP affirmed its denial in a final adverse determination dated March 16, 2010.

III ISSUE

Did PHP properly deny the Petitioner coverage for an abdominoplasty?

IV ANALYSIS

Petitioner's Argument

In her grievance form directed to PHP, Petitioner explained the background which led to her filing the appeal:

I have spinal stenosis in my lower back and even though I have lost this weight it has made it worse due to the fact that the apron on my lower abdomen puts more pressure on my lower back. I have been to XXXXX pain clinic which helped as long as I got the shots and the nerve endings burnt but I can't do this the rest of my life and it must be costly for you also. . . . The procedure is only \$7500.00 can't you look at the long term effects for both of us. No more pain clinic. No more pain meds (a few trips to the pain clinic would pay for this). At this time I can't stand for very long. I can't play very well with my grandchildren. I lost the weight so I could do these and better my health so please reconsider this.

On October 8, 2009, Dr XXXXX wrote requesting authorization:

[Petitioner] has undergone a 50 pound weight loss over the past 12 months, down to 170 pounds.

* * *

She has had considerable back pain and neck pain and has been told that the weight of this panniculus is accentuating the lower back pain

component by her family physician. I would tend to agree. In addition, she has considerable overlap of upper and lower abdominal panniculi with skin changes.

Physical examination shows a large panniculi with skin irregularities.

In his February 10, 2010, letter, Dr. XXXXX wrote in support of Petitioner's surgery with

Dr. XXXXX:

[T]he patient has done well losing weight. This has not helped her back as hoped. She does have a history of spinal stenosis. Previously she has undergone physical therapy, epidural injections at the XXXXX Pain Clinic and Osteopathic Manipulation and the weight loss. She continues to have back pain and I hope the above surgery will help with that.

Respondent's Argument

In its March 16, 2010, final adverse determination, PHP denied coverage for the services stating:

The original decision to deny your request was upheld because your benefits do not include coverage for abdominoplasty when criteria are not met. This decision was based on the following sections of your Certificate of Coverage. A copy of the following information is attached.

- Section 2: What's Not Covered – Exclusions, Q.1
- Amendment to All Commercial Plans, #2

Section 2 provides that coverage is not provided for “[h]ealth services and supplies that do not meet the definition of a Covered Health Service” which the certificate defines in the Amendment to All Commercial Plans, (effective 2/1/09):

Covered Health Service(s) – those health services determined by us to be Medically Necessary and provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

PHP's medical policy regarding panniculectomy/abdominoplasty procedures includes the following provisions:

Policy Statement:

PHPMM will cover panniculectomy/abdominoplasty procedures through the medical benefit that meet established criteria, supported by clinical evidence, national standards or guidelines, and approved by the Medical Director utilizing the following clinical determination guidelines. Panniculectomy/abdominoplasty procedures **require notification in**

advance of the health service.

* * *

Clinical Determination Guidelines

Criteria (conditions that must be met) for services to be classified as medically necessary and covered:

1. Panniculus hangs below the level of the symphysis pubis, as demonstrated in the medical record and preoperative photographs.
AND
2. Medical documentation must show a stable weight for a minimum of six (6) months post bariatric surgery or weight loss program
AND
3. The enrollee's medical records must show documentation of ulcerations or infections (bacterial or fungal) unresponsive to at least six (6) months of conservative management by a physician or infectious disease specialist. Photographic documentation (frontal and lateral views) may be requested showing the presence of chronic skin changes.
AND
4. The procedure must be ordered and performed by a plan-affiliated or contracted general or plastic surgeon. It must be performed at an affiliated or contracted facility.
AND
5. Must reference the enrollee's benefit plan
AND
6. Medical Director review is required for all cases.

In making its determination, PHP requested from Dr. XXXXX documentation of a stable weight for a minimum of 6 months and documentation of ulcerations or infections under the panniculus for at least 6 months. The two responses received from Dr. XXXXX stated, "Pt has lost 12 additional pounds in the last 2 months" and "Pt has lost 15 additional pounds in last 2 months." The PHP criteria state the weight must be stable for a minimum of six months. Also, the request for documentation of ulcerations or infections was not addressed.

PHP argues that the requested surgery does not meet its criteria for coverage and therefore its denial was appropriate.

Commissioner's Review

In order to resolve the question of whether the Petitioner's abdominoplasty was medically necessary, pursuant to MCL 550.1911(6), the Commissioner obtained the recommendation of an independent review organization (IRO). The review was conducted by a

physician who is board certified in plastic surgery and has been in active practice for over ten years. The IRO reviewer recommended upholding PHP's denial of coverage for abdominoplasty.

The IRO reviewer's report explained:

[T]he photographs provided for review do not document the presence of skin ulcerations or intertrigo or that the pannus hangs over the symphysis pubis. . . . [T]here were no medical records documenting office visits for treatment of skin infections or ulcerations provided in the case file. . . . [T]he mere presence of a pannus and its psychological or physical burden on a patient does not automatically make its removal medically necessary. . . . [T]here is no evidence in the medical literature that would support the medical necessity of removing a pannus in the presence of arthritis, disc disease of the spine or spinal stenosis.

Pursuant to the information set forth above and available documentation the [reviewer] determined that an abdominoplasty is not medically necessary for treatment of the member's condition.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise and professional judgment. The Commissioner can discern no reason why the IRO's recommendation should be rejected in the present case.

Therefore, the Commissioner accepts the conclusion of the IRO and finds that PHP's denial of abdominoplasty was appropriate under the terms of the certificate and medical policy.

V ORDER

The Commissioner upholds PHP's March 16, 2010, final adverse determination. PHP is not required to cover the Petitioner's abdominoplasty.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this

Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.