

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 117973-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 12th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On November 8, 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.* The Commissioner reviewed the material submitted and accepted the request on November 16, 2010.

Since this case involved medical issues, the Commissioner assigned the case to an independent review organization which provided its analysis and recommendation on December 3, 2010.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits through the XXXXX of Education, which is an underwritten group. The benefits are defined in BCBSM's *Comprehensive Health Care Copayment Certificate Series CMM 10,000* (the certificate).

On July 24, 2008, the Petitioner underwent surgery for endoscopic brow lift, medical upper lid skin excision, lower lid blepharoplasty and cheek lift. BCBSM denied coverage for all charges related to the surgery ruling that the services were not medically necessary.

The Petitioner appealed BCBSM's denial of coverage. After a managerial-level conference on August 18, 2010, BCBSM did not change its decision and issued a final adverse determination dated September 9, 2010.

III. ISSUE

Is BCBSM required to provide coverage for Petitioner's July 24, 2008 surgery?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states that she underwent upper blepharoplasty surgery years ago and BCBSM provided coverage for the procedure. On July 24, 2008, she underwent the surgery again for the same eye condition. She argues that the eyebrow lift and upper blepharoplasty procedures are medically necessary so BCBSM is required to provide coverage.

BCBSM's Argument

In its September 9, 2010, final adverse determination, BCBSM explained its decision:

. . . Based on the operative report, the surgery was not medically necessary as indicated in that report. It was primarily performed for cosmetic purposes. As a result, no further payment can be issued and the approval for the \$800 charge was approved in error. However, we will not adjust our records at this time since no actual payment was issued.

. . . As indicated on Page 4.2 of your Certificate, "In order to be paid, services must be medically necessary, as defined in Section 7..." Page 7.3 indicates:

Medically Necessary

A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

Medical necessity for payment of professional provider services:

Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and
- Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or

sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

NOTE: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

Because our consultants determined that the services were not medically necessary, the charges remain your liability.

Commissioner's Review

The Commissioner presented the question of whether the Petitioner's surgery was medically necessary to an independent medical review organization (IRO). The IRO reviewer is a physician who is board certified in ophthalmology and has been in active practice for more than 15 years. The IRO reviewer's report included this analysis:

[T]his case involves a 52 year-old female who has a history of excess skin around her eyes. On 7/24/08, the member underwent endoscopic brow lift, upper lid excess skin excision, lower lid blepharoplasty and cheek lift one. At issue in this appeal is whether these services were medically necessary for treatment of the member's condition.

[T]here are no preoperative medical records reporting that the member had complaints or concerns about her peripheral vision. . . . [T]hese issues were only raised in the member's appeal letter. . . . [T]he only accepted medical indications for blepharoplasty and/or brow lifts are for treatment of visual interference or obstruction in the visual field. . . . [V]isual interference and obstruction in the visual field are not documented in the member's medical records. . . . [T]he visual field test results provided in the case file show a modest superior field restriction of 10 to 15 degrees on the right and no superior field restriction on the left with no restriction of field within the central 40 degrees of either eye. . . . [T]he photographs provided for review do not show enough brow ptosis or excess skin to account for significant visual or peripheral vision limitations. . . . [I]n these photographs, the brows are not low enough or heavy enough to be causing an impediment. . . . [T]he information provided for review does not demonstrate that the surgery that the member underwent was medically necessary for treatment of her 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 reviewer’s analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner accepts the recommendation of the IRO reviewer that the surgery was not medically necessary and finds that BCBSM’s denial of coverage was consistent with the terms of the certificate.

V. ORDER

BCBSM’s September 9, 2010, final adverse determination is upheld. BCBSM is not required to provide coverage for the Petitioner’s July 24, 2008 surgery.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or 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.

R. Kevin Clinton
Commissioner