

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

**In the matter of**

**XXXXX**

**Petitioner**

**File No. 118232-001**

**v**

**American Community Mutual  
Insurance Company  
Respondent**

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**Issued and entered  
this 19<sup>th</sup> day of July 2011  
by R. Kevin Clinton  
Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On December 16, 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the information received and accepted the request on December 27, 2010.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization, which completed its review and sent its recommendation to the Commissioner on January 10, 2011.

**II. FACTUAL BACKGROUND**

On November 11, 2010, Petitioner requested authorization for back surgery from American Community. American Community denied the request, ruling that the surgery was not medically necessary.

The Petitioner appealed American Community's decision through its internal grievance process. American Community maintained its position and issued its final adverse determination December 9, 2010.

### III. ISSUE

Did American Community properly deny authorization for the Petitioner's back surgery?

### IV. ANALYSIS

#### Petitioner's Argument

The Petitioner states that he has had back problems since 2004. For the past several years his pain was managed by multiple epidural steroid injections. These have provided shorter and shorter periods of relief. He also had chiropractic treatment which did provide some relief. The Petitioner also takes medication for the pain. Over the last two years, his back pain has gotten worse and he wants surgery to relieve his pain, which his doctors are recommending. Petitioner argues fusion surgery at L5-S1 is the only way to get long-term relief. He believes this surgery is medically necessary and should be a covered benefit.

#### Respondent's Argument

In its December 9, 2010, final adverse determination American Community denied coverage stating:

This policy provides benefits for services that are necessary to the care or treatment of an illness or injury. The policy states "Necessary to the Care or Treatment of Illness means medical, surgical, psychiatric, substance abuse or other health care services, supplies, treatment, procedures, drug therapies or devices which are determined by American to be necessary to treat the insured individual's condition. Determination of necessity is done on a case by case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a doctor has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular injury or sickness does not, alone, mean that it is Necessary to the Care or Treatment of an Illness. . . ."

\* \* \*

On October 29, 2010, a letter was sent to you and XXXXX, advising you that your records were reviewed by an independent consultant. It is the opinion of the consultant that "The patient's neurological examination is normal and the MRI showed degenerative disc disease at L5-S1 with lateral recess stenosis on the left without evidence of instability. Thus the medical records do not support the necessity of this procedure." . . .

On November 2, 2010 . . . your records were once again reviewed by a different independent consultant. . . . [T]he opinion of the second consultant was "There is a lack of any significant degenerative findings or instability at the L5-S1 level

to warrant a fusion procedure. As such, the clinical documentation provided does not support the medical necessity of the request at this time.” . . .

American Community contends its decision was in compliance with the terms of the certificate.

### Commissioner's Review

The question of whether the Petitioner's surgery is medically necessary was presented by the Commissioner to an independent medical organization (IRO) for review. The IRO reviewer assigned to this case is a physician who is board certified in orthopedic surgery and has been in active practice for more than 15 years. The reviewer is familiar with the medical management of patients with the Petitioner's condition. The reviewer's report included the following analysis and conclusions:

[T]he member does not meet generally accepted criteria for lumbar fusion. . . .

[T]here is no documented instability or a concern for a tumor in this case. . . .

[T]here is no evidence of severe stenosis on MRI. . . . [D]ecompression and fusion surgery is not medically necessary for treatment of the member's condition. (Resnick DK. Evidence based guidelines for the performance of lumbar fusion. *Clin Neurosurg.* 2006; 53: 279-284.)

Pursuant to the information set forth above and available documentation, [the reviewer] determined that the requested L5-S1 decompression/fusion surgery 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, a recommendation from the IRO 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.

The Commissioner finds that American Community correctly applied the terms of the certificate in denying coverage for the Petitioner's requested surgery.

**V. ORDER**

American Community's final adverse determination of December 9, 2010, is upheld. American Community is not required to cover the Petitioner's requested surgery.

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 60 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.

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R. Kevin Clinton  
Commissioner