

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████,

Petitioner,

v

File No. 145266-001

All Savers Insurance Company,

Respondent.

Issued and entered
this 13th day of January 2015
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 8, 2014, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material received, the Director accepted the case on December 15, 2014.

The Petitioner receives medical benefits under a group plan underwritten by All Savers Insurance Company (All Savers). United Healthcare Life Insurance Company (UHC), an affiliate of All Savers, provides administrative services for the plan, including utilization review and grievances. The Director notified UHC of the external review request and asked for the information it used to make its adverse determination.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in a certificate of coverage issued by All Savers (the certificate). The coverage was effective on March 1, 2012.

The Petitioner has had low back pain since 2009. His symptoms were exacerbated by an automobile accident in 2012.

On March 14, 2014, the Petitioner had an evaluation at the ██████████ that included magnetic resonance imaging (MRI) and an X-ray. After a selective nerve root injection on March 17, 2014, his physician determined he was a candidate for surgery and on March 18, 2014, he had "a lumbar laminotomy and foraminotomy including partial facetectomy with decompression of the nerve roots and disc decompression of the right L5-S1."

UHC, acting for All Savers, denied coverage for this surgery on the basis that it was not medically necessary to treat his condition. The Petitioner appealed the denial through the UHC internal grievance process. At the conclusion of that process, UHC issued a final adverse determination dated October 2, 2014, affirming its denial. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did UHC correctly deny coverage for the Petitioner's March 18, 2014 medical services?

IV. ANALYSIS

Respondent's Argument

UHC had the Petitioner's case reviewed by an outside medical review organization. Following that review, UHC issued a final adverse determination dated October 2, 2014, in which it told the Petitioner:

. . . Considering the reviewing doctor's opinion and your Certificate of Insurance, the [*grievance*] panel determined the services performed by [REDACTED] on March 18, 2014, was not medically appropriate and consistent to treat [your] diagnosis.

* * *

Your plan states in part the following:

Medical Necessity or Medically Necessary – we will determine if a medical service satisfies the following requirements before we will pay any Benefits:

1. must be medically appropriate and consistent to treat an Injury or Sickness;
2. cannot be excessive in scope, duration or intensity;
3. must be safe, effective and appropriate with regard to accepted standards or medical practice at the time when the medical service is provided;
4. cannot be provided primarily for the comfort or convenience of the Covered Person, a family member or a health care provider;
5. could not be omitted without an adverse affect; and
6. must be the most cost-effective. This means there is not other similar or alternate medical service available at a lower cost.

A final decision to provide medical services can only be made between the Covered Person and the health care provider.

However, we will not pay Benefits if we are not satisfied that a medical service meets all of the above requirements.

Petitioner's Argument

On the external review request form the Petitioner said:

I would like for the health insurance to pay for my doctor bill. I pay a lot for my insurance each month, my insurance should pick up the bill.

The Petitioner also included with his external review request a December 3, 2014, letter from [REDACTED] that explained the need for the surgery:

[The] denial letter states that the reason medical necessity could not be established in this case was because [the Petitioner] did not have any recent conservative treatment and previous treatment saw some results in relieving his pain. Although yes at first [he] did have relief of about 85% from Physical Therapy and Chiropractic Care that relief was short lived and the pain continued to return. Also yes 2009 was the only time he was seen for Chiropractic Care but for Physical Therapy he started that in 2009 and he continued to see [other doctors] up until he came to see us at LSI. You also noted that the ESI [*epidural steroid injections*] provided 60% relief which was true for one shot but his last shot provided only 20% relief for his pain. [He] has suffered from his back pain for over 6 years and this pain does adversely affect his ADLs [*activities of daily living*]. He did have significant findings of radiculopathy to warrant a lumbar surgery. He had a sharp back pain that traveled to the foot, he had lower extremity, leg, and foot numbness and tingling, he had low back, lower extremity, buttock, thigh, calf, and foot pain; he also had lower back stiffness and bilateral burning.

Due to these symptoms he could not stand for long periods of time, could not lift over 5 lbs, he was unable to perform household chores, and this directly affected his career. At that point [the Petitioner] turned to [REDACTED] to get his life back. His MRI revealed at the L5/S1 level he suffered from Degenerative Disc Disease, Bulging Disc Disease, Foraminal Stenosis, and Facet Degen/Hypertrophy. He was then ordered a Selective Nerve Root Block to make sure surgery was done at the appropriate level. The S1 SNRB did relieve 80% of his pain and it was determined . . . L5/S1 LFD was the appropriate surgery. Again we ask you to please review all of the records we are providing and they will show not only was this surgery warranted but it was also able to help [the Petitioner] return to his normal life.

* * *

By choosing to have surgery at the [REDACTED], our patient was able to avoid the need for inpatient hospital care, extensive physical therapy, and months of recuperation. All of these factors would have not only increased risk to our patients' health, but would have significantly increased your coverage costs.

Director's Review

Covered services must be "medically necessary" as that term is defined in the certificate (p. 51, quoted above). To determine if the surgery the Petitioner received was medically necessary to treat his condition, the Director assigned this case to an independent review organization (IRO) as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO physician reviewer is certified by the American Board of Orthopaedic Surgery in general orthopaedic surgery and is in active practice. The IRO report included the following analysis and recommendation:

Reviewer's Decision and Principal Reasons for the Decision:

It is the determination of this reviewer that the services performed on March 18, 2014 at [REDACTED] [REDACTED] were medically necessary for the treatment of the enrollee's condition.

Clinical Rationale for the Decision:

The peer reviewed literature suggests that surgical treatment of defined pathology could perhaps be better in the long term, especially in younger patients. In this clinical scenario, the enrollee's symptoms were moderate with failure of conservative treatment including physical therapy, chiropractic care and epidural steroid injections (ESI)

In a study by Malmivaara, no previous randomized trial has assessed the effectiveness of surgery in comparison with conservative treatment for spinal stenosis. Although patients improved over the 2-year follow-up regardless of initial treatment, those undergoing decompressive surgery reported greater improvement regarding leg pain, back pain, and overall disability. The relative benefit of initial surgical treatment diminished over time, but outcomes of surgery remained favorable at two (2) years."

Practice guidelines suggest that non-operative care be offered prior to the consideration of surgery. The guidelines do not demand that this care be offered within a specific interval prior to surgery. The enrollee's prior conservative care meets the practice guidelines. The use of the nerve root injection documented concordance of symptoms to MRI pathology in this clinical scenario. Based on the failure of previous conservative care and concordance of pathology, the services performed on March 18, 2014 at [REDACTED] [REDACTED] [REDACTED] were medically necessary.

Recommendation:

It is the recommendation of this reviewer that the denial issued by United Healthcare Life Insurance Company for the services performed on March 18, 2014 at [REDACTED] be overturned.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] 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 and is not contrary to any provision of the Petitioner's certificate of coverage. MCL 550.1911(15). The Director can discern no reason why the IRO's recommendation should be rejected in the present case.

The Director finds that the surgery the Petitioner received on March 18, 2014 was medically necessary to treat his condition and is therefore a covered benefit.

V. ORDER

The Director reverses UHC's October 2, 2014 final adverse determination.

All Savers shall immediately cover the Petitioner's surgery and related care on March 18, 2014, and shall, within seven days of providing coverage, furnish the Director with proof that it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, toll free at 877-999-6442.

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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director