

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. 147270-001

Blue Cross Blue Shield of Michigan,

Respondent.

**Issued and entered
this 4th day of May 2015
by **Randall S. Gregg**
Special Deputy Director**

ORDER

I. PROCEDURAL BACKGROUND

On April 13, 2015, ██████████ (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 submitted, the Director accepted the request on April 20, 2015.

The Petitioner receives health care coverage through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM provided its response on April 28, 2015.

To address the medical issues in the case, the Director assigned it to an independent medical review organization which provided its analysis and recommendation on May 4, 2015.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs LG*¹ (the certificate).

On September 12, 2014, the Petitioner had breast reduction surgery (CPT code 19318). BCBSM denied coverage, saying the surgery was not medically necessary.

¹ BCBSM form no. 781E, approved 08/14.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, BCBSM affirmed its denial in a final adverse determination dated March 26, 2015. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's breast reduction surgery?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form, the Petitioner said:

Breast reduction, reimbursement for surgery on 9/12/14. Total claim is for \$6,210.00.

The Petitioner's physician explained the need for the surgery in a November 5, 2014 letter:

This letter is in regards to my patient, [the Petitioner], who recently had a breast reduction surgery. She pursued this secondary to chronic back pain which resulted from her larger breast size on her small body frame. She went from a DD bra size on a small 130# frame to a C cup which is better suited for her frame. Since the surgery she has had positive results with improvement in her back pain. I think that it would be in her best interests to consider payment for this procedure due to the pain and improvement she has seen with the reduction surgery.

The Petitioner's gynecologist, in a February 10, 2015, letter, also wrote in support of the procedure:

... [The Petitioner] underwent bilateral breast reduction on 9/12/2014 for back pain. As a result of this surgery, the patient was diagnosed with atypical ductal hyperplasia. I feel this surgery was beneficial as it has resulted in the identification of the atypical ductal hyperplasia and a follow up care plan has been established for management.

BCBSM's Argument

In its final adverse determination, BCBSM's representative told the Petitioner:

... With regard to your surgery claim, I confirmed that the claim was processed correctly, and following a medical review, the denial is maintained. Our consultant confirmed that medically necessity is not met. Under the terms of

coverage, we pay for medically necessary surgery. Because medical necessity is not met, you remain liable for the billed amount of \$6,210.00.

As explained in your plan . . . [BCBSM] does not pay for professional provider services for cosmetic surgery when performed primarily to improve appearance, except as listed on Page 101. *Section 3: What BCBSM Pays For*, Page 101, lists when BCBSM pays for cosmetic surgery, which supports that we do not pay for cosmetic surgery primarily to improve appearance. Your procedure was submitted with a diagnosis code V501 (plastic surgery for unacceptable cosmetic appearance). Unfortunately, this diagnosis is not covered under the terms of your policy.

In order to ensure your appeal was given all consideration, a board-certified M.D. in General Surgery reviewed your claim, your appeal, and your health care plan benefits for [BCBSM]. Our consultant explained.

Per BCBSM medical policy (*Reduction Mammoplasty for Breast-Related Symptoms*), the patient did not meet criteria for medical necessity.

According to the patient's Body Surface Area, 338 grams of breast tissue needed to be removed per breast. The provider removed 130 grams from the left breast and 120 grams from the right breast, according to the submitted pathology report. Denial upheld.

Director's Review

The question of whether the Petitioner's surgery was medically necessary was presented 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 Plastic Surgery; diplomate, American Board of Surgery; and is in active practice. The IRO report included the following analysis and recommendation:

Clinical Rationale for the Decision:

According to the plastic surgeon's consultation note, this enrollee complained of neck, shoulder and back pain due to her large breasts. These are the typical complaints of women who suffer from macromastia. A work-up for other possible causes of her symptoms is not documented, and she had not seen a musculoskeletal specialist. The records do not include any primary care physician (PCP) notes that document medical treatment for chronic musculoskeletal pain such as chiropractic care, physical therapy, analgesics or support bras. Finally, the reduction of only 250 grams of tissue falls into the cosmetic range on Schnur guidelines for a woman with a BSA of 1.65. Confirmatory evidence of symptoms, such as history of conservative therapy, photographic evidence of severe breast hypertrophy or a history of frequent

primary care physician visits for musculoskeletal symptoms is necessary to support the history provided by the plastic surgeon.

In addition, the requested breast reduction is not medically necessary based on the Milliman Guidelines (18th Edition) "Reduction Mammoplasty." The Milliman guidelines for reduction mammoplasty require the following:

- Estimate of breast volume of 750 cc or greater or bra cup of D or greater
- A minimum reduction of greater than 250 grams of breast tissue from each breast
- Breast size interferes with activities of daily living (ADL's) as indicated by one or more of the following:
 - Chronic breast pain
 - Persistence redness or erythema (intertrigo) below breasts
 - Upper or lower back pain
 - Thoracic kyphosis
 - Shoulder pain
 - Severe bra strap grooving or ulceration of shoulder
 - Arm numbness consistent with brachial plexus compression syndrome
 - Headaches
 - Cervical pain
 - Nipple position greater than 21 cm below suprasternal notch
 - Restrictions of physical activities

Failure to relieve symptoms with non-surgical treatment that includes 1 or more of the following:

- Four to eight visits of physical therapy or chiropractic treatments and two to four months of home exercise
- Trial of nonsteroidal anti-inflammatory drugs (NSAIDS)
- Wound care
- Topical antifungal Medications
- Medically supervised weight loss

In this case, the documentation submitted for review does not include primary office notes documenting any conservative treatments, nor are there any evaluations for other possible causes for her symptoms. In addition, the surgeon removed 250 grams total, and the criterion requires a minimum of 250 grams of

tissue from each breast. Relevant conditions that could explain the enrollee's symptoms have been excluded. There is no evidence of breast cancer.

Recommendation

It is the recommendation of this reviewer that the denial issued by [BCBSM] for the reduction mammoplasty surgery performed on September 12, 2014 be upheld.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the IRO's 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. In addition, the IRO recommendation is not contrary to any provision of the Petitioner's certificate of coverage. MCL 550.1911(15).

The Director, discerning no reason why the IRO's recommendation should be rejected in this case, finds that the Petitioner's breast reduction surgery was not medically necessary and is therefore not a covered benefit under the certificate.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 26, 2015.

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 Michigan 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