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. 149748-001**

McLaren Health Plan,

Respondent.

Issued and entered
this 12th day of November 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

(Petitioner) had outpatient surgery on October 17, 2014. Her health plan, McLaren Health Plan (McLaren), denied coverage for the procedure.

On September 8, 2015, , the Petitioner's husband and authorized representative, filed a request with the Director of Insurance and Financial Services for external review of McLaren's denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The initial request was incomplete and additional information was provided on September 15, 2015.

The Petitioner receives health care benefits through McLaren, a Medicaid health maintenance organization. The Director immediately notified McLaren of the external review request and asked for the information it used to make its final adverse determination. McLaren responded on September 18, 2015. After a preliminary review of the material submitted, the Director accepted the request on September 22, 2015.

Initially the issue in this external review appeared to involve only contractual interpretation so it was not assigned to an independent review organization (IRO) for a medical opinion. However, upon further evaluation, the Director determined that the case involved a medical issue and it was assigned to an IRO. The IRO submitted its recommendation to the Director on October 22, 2015.

II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in the *Member Certificate of Coverage* (the certificate).

On October 17, 2014, the Petitioner had outpatient rhinoplasty and other services performed by a surgeon who is not in McLaren's network. The charge was $5,208.00. The Petitioner's husband paid in full for the surgery and in December 2014 requested reimbursement from McLaren.

When McLaren declined to retroactively authorize and cover the surgery, the Petitioner appealed through McLaren's internal grievance process. At the conclusion of that process, McLaren maintained its denial in a final adverse determination dated March 17, 2015.[1] The Petitioner now seeks a review of that final adverse determination from the Director.

III. Issue

Did McLaren properly deny coverage for the Petitioner's rhinoplasty surgery?

IV. Analysis

A

On September 30, 2014, the Petitioner was treated by an otolaryngologist for a sinus infection and was advised to see a plastic surgeons to correct her nasal problems. She was given the names of three plastic surgeons; the one she selected is not in McLaren's network.

On October 14, 2014, the Petitioner consulted with the plastic surgeon. The surgeon's notes from that day said, "This is a 36 year old patient who had a previous rhinoplasty in Syria and is concerned about her breathing and the cosmetic appearance." The surgeon recommended "cartilage graft to dorsum, lower cartilaginous dorsum, remove septal spur, alar strut grafts and spreader grafts." The surgery was performed on October 17, 2014.

According to McLaren, on December 5, 2014, it received a request from the Petitioner for reimbursement of the amount paid to the plastic surgeon. McLaren says it spoke with the Petitioner's authorized representative on December 12, 2014, and told him:

> [that] this procedure requires prior authorization and that [McLaren] has never received a request for authorization. [McLaren] also explained that this procedure has not been billed to McLaren Health Plan and we would need to have a claim submitted by the provider.

At the Petitioner's request, McLaren contacted the plastic surgeon's office and spoke with the billing manager on December 16, 2014:

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1 McLaren acknowledged that it mailed the final adverse determination to an incomplete address. On August 28, 2015, McLaren express-mailed a copy of the final adverse determination to the Petitioner. Thus, the Petitioner's request for an external review was deemed timely.

> She indicated that the member and representative were told in advance that this procedure was a cosmetic procedure and that they would not be billing any medical insurance. The billing manager indicated that the member's representative understood this and payment was made before the surgery. The billing manager said she would be sending information to assist with the member's request as well as submitting a claim.

In March 2015 the McLaren appeals committee reviewed the Petitioner's request for retroactive authorization for the surgery and denied it. McLaren issued a final adverse determination dated March 17, 2015, which said the rhinoplasty was not medically necessary:

> The McLaren Health Plan Appeals Committee has carefully reviewed the appeal . . . requesting retro authorization for Rhinoplasty which was filed by the member on February 27, 2015.
>
> After reviewing the information provided, McLaren Health Plan is unable to approve the retro authorization request for Rhinoplasty. The Appeals Committee reviewed your request, including the medical records provided by [the plastic surgeon]. The denial is upheld due to the fact that the submitted documentation does not show nasal airway obstruction causing significant symptoms and photos to demonstrate an external nasal deformity and documentation that the symptoms persist despite 3 months of conservative management and airway obstruction that did not respond to septoplasty and turbinectomy alone. The criteria used to reach this decision is the Apollo Managed Care Criteria Bariatric Surgery for Nasal Surgery Rhinoplasty, which is widely used and evidence-based criteria.

In its response to the external review notice dated September 18, 2015, McLaren further explained its rationale for denying coverage:

> The member had a Rhinoplasty performed by . . . a non-contracted provider. Rhinoplasty requires prior authorization. McLaren Health Plan did not receive notice of this procedure until after the procedure had been completed. Information was presented following the procedure and reviewed. The Apollo Managed Care criteria for nasal surgery . . . states Rhinoplasty is considered cosmetic unless specific medical indications for reconstructive surgery are met, e.g.: Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when all of the following criteria are met"
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> - Nasal airway obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing), *and*
> - Photos demonstrate an external nasal deformity, *and*
> - There is an average 50% or greater obstruction of nares (e.g., 50% obstruction of both nares, or 75% obstruction of one nare and 25% obstruction of other nare, or 100% obstruction of one nare), documented by endoscopy, CT scan or other appropriate imaging modality, *and*

- Obstructive symptoms persist despite conservative management of three months or greater, which includes, where appropriate, nasal steroids, or immunotherapy, *and*
- Airway obstruction will not respond to septoplasty and turbinectomy alone.

McLaren Health Plan did not receive documentation indicating that the above criteria has been met. According to Apollo Managed Care criteria, all criteria must be met in order for a rhinoplasty to be considered medically necessary.

B

According to the certificate (p. 7), covered benefits must be medically necessary. The certificate (p. 15) excludes coverage for services that are not medically or clinically necessary. McLaren declined to retroactively authorize coverage (and reimbursement) for the Petitioner's surgery because it determined that it was not medically necessary; the Petitioner had not met its criteria.

The question of whether Petitioner's rhinoplasty was medically necessary was presented to an independent review organization (IRO) for analysis and a recommendation as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO physician reviewer is board certified in plastic surgery, has been in active practice for more than twelve years, and is familiar with the medical management of patients with the Petitioner's condition. The IRO report included the following recommendation and analysis:

Recommended Decision:

The MAXIMUS physician consultant determined that rhinoplasty performed on 10/17/14 was medically necessary for treatment of the member's condition, except for the cosmetic portion of the surgery related to the cephalic trim and osteotomies that were performed.

Rationale:

* * *

The member was referred by her primary care physician to the operating surgeon due to sinus and nasal pain. The member's chief complaint upon being seen by the plastic surgeon was nasal deformity and she was also concerned about her breathing and cosmetic appearance. The MAXIMUS physician consultant indicated that the examination documentation is consistent with nasal airway obstruction as the member had pronounced lateral collapse on inspiration and a septal spur. The physician consultant also indicated that [the] operative note is also consistent with a functional deficit related to nasal airway obstruction, as spreader grafts were performed as well as turbinectomies and alar batten and columella graphs. The consultant explained that the cosmetic portion of the surgery appears to be related to the cephalic trim and osteotomies that were performed. The physician consultant also explained that this case should be considered one of both cosmetic and reconstructive goals. The consultant noted that there is sufficient evidence that the

> member had significant nasal airway obstruction, as supported by the operative note and other medical documentation. The operative report noted 70 to 85% obstruction from the nasal turbinates. The consultant indicated that photographs were not provided for review, but were unlikely to show critical aspects of nasal airway obstruction as the member had internal nasal valve problems and turbinate hypertrophy as significant parts of the nasal obstruction. The consultant also indicated that conservative management would have been unlikely to provide substantial benefit given the documented severity of the member's condition. The physician consultant explained that septoplasty and turbinectomy alone would not have corrected the internal nasal valve problem as well as the external nasal valve problem in this case.
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> According to the American Academy of Plastic Surgeons' Positions on Recommended Insurance Criteria for nasal surgery, "Reconstructive rhinoplasty transforms nasal abnormalities or damaged nasal structures to a more normal state. Nasal surgery is considered reconstructive surgery and medically necessary to improve nasal respiratory function, treat anatomic abnormalities caused by birth defects or disease or revise structural deformities resulting from trauma." The literature also supports that there can be conditions that necessitate treatment with a rhinoplasty for functional impairment. The physician consultant explained that the member clearly had significant nasal obstruction producing a predictable pattern of impairment, which was supported by examination detail, the operative note and other medical documentation. The consultant also explained that the planned procedure was consistent with standard of care following nasal obstruction, which is a functional deficit.
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> The consultant indicated that corrective measures should be considered reconstructive and medically necessary, but that there are aspects of the member's case that appear to be aesthetic treatment. The American Academy of Plastic Surgeons' Positions on Recommended Insurance Criteria for nasal surgery states that if 2 procedures, one reconstructive and one cosmetic, are performed on the nose during the same operative session, the surgeon should accurately distinguish which components of the procedure are reconstructive and which are cosmetic. The physician consultant explained that in this case, the procedure was approximately 75% to 85% reconstructive.
>
> Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that rhinoplasty performed on 10/17/14 was medically necessary for treatment of the member's condition, except for the cosmetic portion of the surgery related to the cephalic trim and osteotomies that were performed. [Citations omitted.]

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 review is based on extensive experience,

expertise, and professional judgment. In addition, the IRO's 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 rhinoplasty, with the exception of the cosmetic portion of the surgery related to the cephalic trim and osteotomies,[2] was medically necessary, standard of care treatment for the Petitioner's condition, and is therefore is a covered benefit.

V. ORDER

The Director reverses McLaren's March 17, 2015, final adverse determination. McLaren shall immediately cover the Petitioner's October 17, 2014, rhinoplasty and shall, within seven days of providing coverage, furnish the Director with proof it has implemented this order.

McLaren is not required to cover the cosmetic portion of the surgery (cephalic trim and osteotomies) performed in conjunction with the rhinoplasty.

To enforce this order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Sections, at this toll free telephone number: (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.

Patrick M. McPharlin
Director

For the Director:

Randall S. Gregg
Special Deputy Director

2 Cosmetic surgery and procedures are excluded from coverage (certificate, p. 13).