Office of Commissioner of Insurance and Safety Fire
Protect | Enforce | Educate | Inform

JOHN F. KING
Commissioner of Insurance and Safety Fire

Two Martin Luther King Jr. Drive
West Tower, Suite 702
Atlanta, Georgia 30334

This is the response from the GA Insurance Commissioner to my complaint along with my response to their response.

January 11, 2024

Orthopaedic Associates
619 Pointe North Boulevard
Albany GA 31721

RE: Our Case Number: 555279977

Dear Orthopaedic Associates:

Thank you for contacting the Office of Insurance Commissioner John F. King.

→ See next page. Insurance IS involved!

Our office received and reviewed the attached reply regarding your complaint filed with our office. Unfortunately, as this group plan is self-funded, and no insurance policy has been issued, our office has no jurisdiction in the case. — Interesting!

Self-funded plans are not subject to the insurance laws of the state of Georgia. These plans are subject to the jurisdiction of the U.S. Department of Labor in accordance with the 1974 Employee Retirement Income Security Act, known as ERISA. This Act established guidelines for self-funded plans and exempted them from state insurance laws and regulations.

Any further questions regarding this plan or requests for assistance should be directed to a benefits representative for the employer. If the employer is non-responsive, you may contact the U.S. Department of Labor (DOL) at 1-866-444-3272 (toll-free) or on their website, www.dol.gov. If you are interested in filing an ERISA appeal, you should follow the guidelines listed in the employee handbook.

We appreciate the opportunity to explain our position in this matter and regret that our office lacks the regulatory authority to resolve your concerns. Please let us know if you have further questions for our office.

Sincerely,

Darnetta Benford

Complaints Analyst
Consumer Services Division
Phone: 404-463-2388/Fax: 404-657-8542
E-mail: dbenford@oci.ga.gov

Enclosure
/ DB

Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Anthem

January 11, 2024

Darnetta Benford
Consumer Services Division
Office of Commissioner of Insurance
716 West Tower
2 Martin Luther King, Jr. Drive
Atlanta GA 30334

Re: Complainant Name:	**Dr. Mark A. Wolgin**
Member Name:	[redacted]
Member ID Numbers:	**PYZAN3946741**
NAIC:	**96962**
Case Number:	**555279977**
Anthem Case Number:	**INQ-COMM-101667**
Related Case Number:	**NA**

Dear Darnetta Benford:

This letter is in response to Case number 555279977.

Our records reflect [redacted] is enrolled in a PPO Core Plan. The effective date of this health plan is January 1, 2022, and the plan is still active. The health benefit plan is through the employer, PEGHP/City of Albany, which is a self-funded group plan. Anthem Blue Cross and Blue Shield (Anthem) is the claims administrator for the plan under an administrative agreement.

In the inquiry submitted to your office, Dr. Mark A. Wolgin contacted the Department of Insurance regarding an inappropriate denial of medical services for [redacted]. Dr. Wolgin has requested the member receive an injection in the bone that will make the bone stronger. Dr. Wolgin believes that Anthem's denial for not medically necessary is not acceptable.

In review of the inquiry, we contacted Utilization Management and were advised of an approval for procedure code 22513, Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance.

According to our records Anthem received additional information from the provider and UM53984094 was entered, and the new information was reviewed. According to the approval letter dated December 19, 2023, the approval was for the following:

Wrong. Information was the same

Your Health Care Team

Member	[redacted]	Date of Birth	[redacted]
Provider	MARK WOLGIN	Status	In-network
Facility	PHOEBE PUTNEY MEMORIAL HOSPITAL	Status	In-network

Request Details

Service	Start Date	End Date	Quantity	Code	Description
Surgical	12/12/2023	02/09/2024	1 Unit(s)	CPT 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidanc

I have attached a copy of the approval letter for UM53984094.

We apologize for the inconvenience this matter may have caused, however, without the additional information, we were unable to approve the procedure previously.

Thank you for allowing us to address the concerns brought forward to your office. If you have any additional concerns or questions, please submit those through the portal. If Dr. Wolgin has additional questions or concerns, please have him contact Provider services at the phone number listed at the back of the member's identification card.

Sincerely,

Lesley Faust
Lesley Faust
Grievances and Appeals Risk Analyst
Grievances and Appeals Regulatory Unit

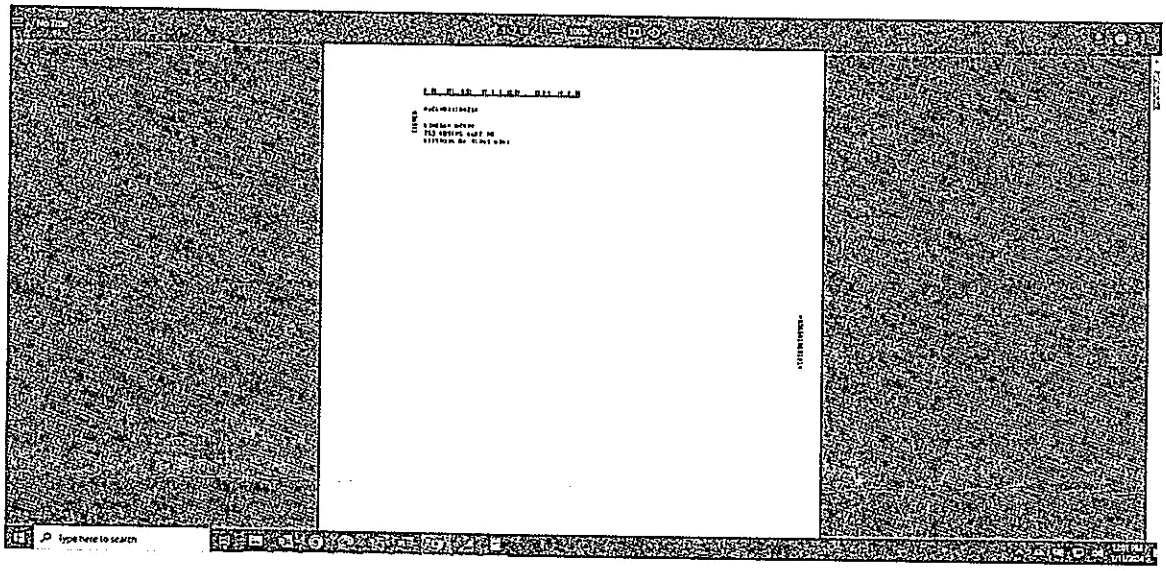
The initial reviewing physician said that treatment for trauma for the spinal fracture was "carved out" (translation: excluded).

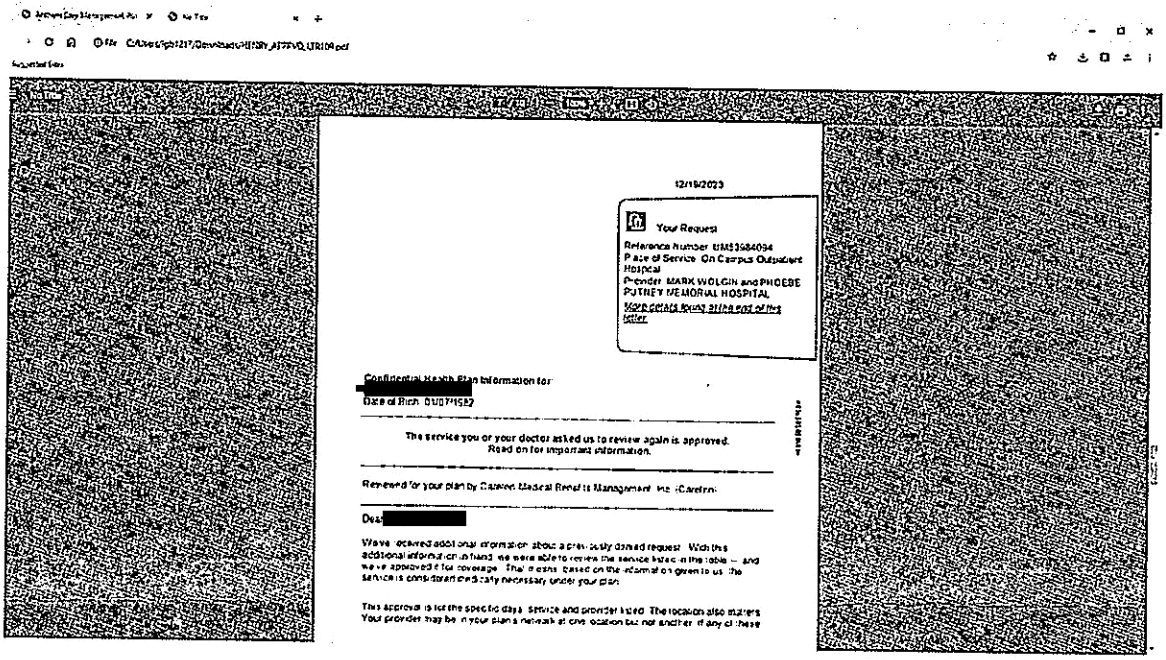
Initial reviewing doctor did not mention lack of physical therapy as reason for denial.

The second reviewing doctor, SEVEN WEEKS LATER, added that detail.

Physical therapy is not the appropriate treatment For this fracture, that only got worse and more deformed by the insurer delay.

Inappropriate, bad faith, and insurer instigated below-standard quality of care.





12/19/2023

Your Request

Reference Number: 61853684094
Place of Service: On Campus Outpatient Hospital
Provider: MARK WOLGIN and PHOEBE PUTNEY MEMORIAL HOSPITAL
More details found at the end of this letter.

Confidential Health Plan information for:
[redacted]
Date of Birth: 01/07/1982

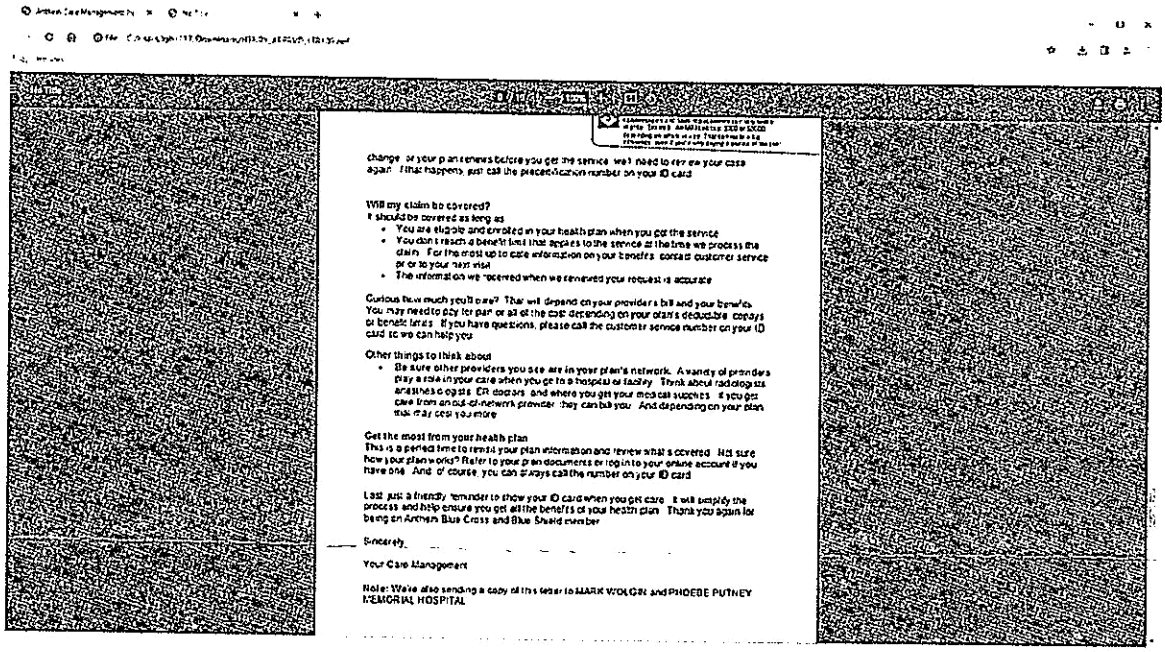
The service you or your doctor asked us to review again is approved.
Read on for important information.

Reviewed for your plan by Cigna Medical Review Management, Inc. (Carelon)

Dear [redacted]

We've received additional information about a previously denied request. With this additional information on hand, we were able to review the service listed in the table — and we've approved it for coverage. That means, based on the information given to us, the service is considered medically necessary under your plan.

This approval is for the specific days, service and provider listed. The location also matters. Your provider may be in your plan's network at one location but not another. If any of these



change, or your plan renews before you get the service, we'll need to review your case again. If that happens, just call the precertification number on your ID card.

Will my claim be covered?
It should be covered as long as:

- You are eligible and enrolled in your health plan when you get the service.
- You don't reach a benefit limit that applies to the service at the time we process the claim. For the most up-to-date information on your benefits, contact customer service or go to your next visit.
- The information we received when we reviewed your request is accurate.

Curious how much you'll owe? That will depend on your provider's bill and your benefits. You may need to pay for part or all of the cost, depending on your plan's deductible, copays or benefit limits. If you have questions, please call the customer service number on your ID card so we can help you.

Other things to think about:

- Be sure other providers you see are in your plan's network. A variety of providers play a role in your care when you go to a hospital or facility. Think about radiologists, anesthesiologists, ER doctors, and where you get your medical supplies. If you get care from an out-of-network provider, they can bill you. And depending on your plan, this may cost you more.

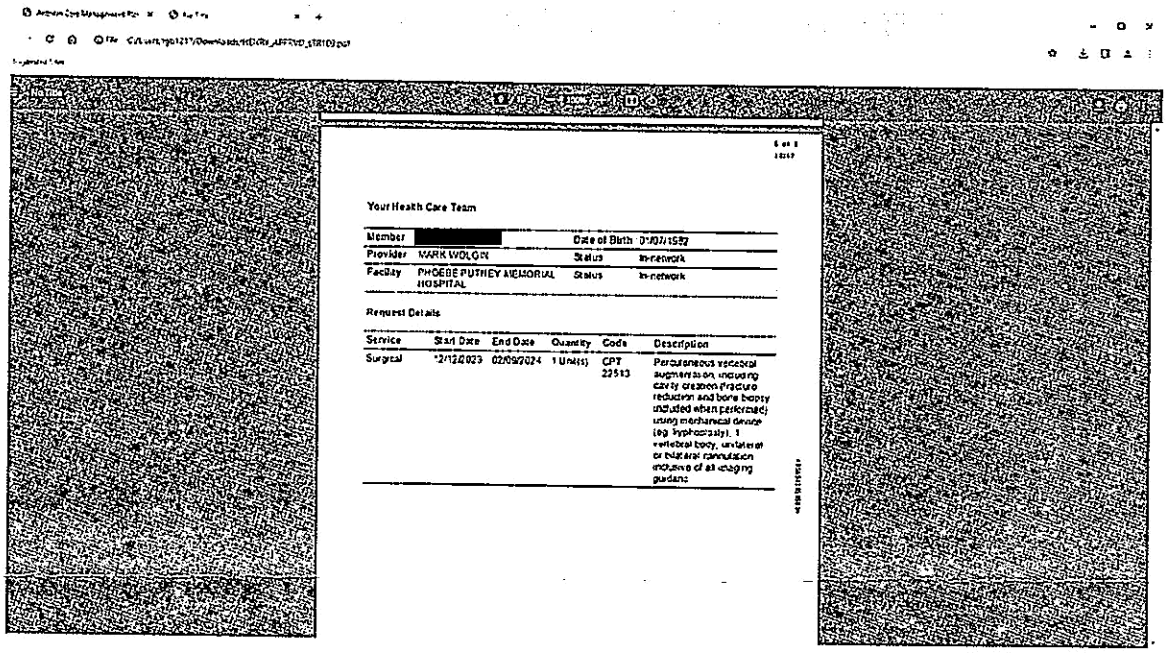
Get the most from your health plan
This is a perfect time to review your plan information and review what's covered. Not sure how your plan works? Refer to your plan documents or log in to your online account if you have one. And, of course, you can always call the number on your ID card.

Last, just a friendly reminder to show your ID card when you get care. It will simplify the process and help ensure you get all the benefits of your health plan. Thank you again for being an Anthem Blue Cross and Blue Shield member.

Sincerely,

Your Care Management

Note: We're also sending a copy of this letter to MARK WOLGIN and PHOEBE PUTNEY MEMORIAL HOSPITAL.



Your Health Care Team

Member	[redacted]	Date of Birth	01/07/1957
Provider	MARK WOLGIN	Status	In-network
Facility	PHOEBE PUTNEY MEMORIAL HOSPITAL	Status	In-network

Request Details

Service	Start Date	End Date	Quantity	Code	Description
Surgical	12/12/2023	02/09/2024	1 Unit(s)	CPT 22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, hydraulic), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

Mark A. Wolgin, MD
Orthopaedic Associates
619 Pointe North Blvd.
Albany, GA 31721
229-883-4707, fax 229-435-1038
www.drwolgin.com

January 18, 2024

Darnetta Benford
Complaints Analyst, Consumer Services Division
Commissioner John King
Office of Commissioner of Insurance and Safety Fire
Two Martin Luther King Jr. Dr.
West Tower, Suite 702
Atlanta, GA 30334

Re: Case 555279977, Patient LH

Though I again am confirmed in my view that the Office of the Commissioner of Insurance for Georgia is completely ineffectual with regard to protecting patients of Georgia from below-standard medical care occurring as a result of inappropriate insurer delays, and though I am under no illusion that your office will do anything to correct this situation, I am writing back to at least document the ineffectiveness of your "efforts."

First, you note that the group plan is self-funded, and no insurance policy has been issued, and your letter states your "office has no jurisdiction in this case." However, in your correspondence to me, you also include a response from the insurer, Anthem BCBS. Last time I checked, Anthem BCBS is an insurance company. If there's no insurance policy, what do they have, a gentlemen's agreement? Are you kidding? Your response includes a response from an insurer, but there is no policy?

Also, the patient, her husband and his employer, and their benefits manager all refer to the patient's care being negatively influenced by the "insurance plan." I therefore see your response as pure semantics and an exercise in bad faith. Clearly, the insurer negatively influenced the outcome in this case, and for your office to dodge all responsibility is simply dereliction of your duty.

Or, maybe you are teaching me (again) that your office is not functioning to protect patients, but is instead established to protect insurance companies.

Second, I need to address the Anthem response, which apparently you think answers the issue, but to be super clear: it does not. The injury date was 10/22/23, and their approval for the surgery was 12/14/23, 7 ½ weeks after the injury, allowing ample time for the compression fracture to compress further, and allowing the opportunity for the kyphoplasty surgery to improve the situation to expire, not to mention allowing the additional weeks of suffering for the patient, who had a treatable condition. Their delay is about as appropriate as waiting five minutes to start CPR on a dying patient. Sure, you started the resuscitation, but through your delay, the result was terrible.

Just like the insurers themselves, your office seem to miss that tiny detail (**or you also could not care less**) that their delay compromised the quality of the care. Though the surgery was technically approved, the delay was insurer generated medical malpractice.

Not that anyone in your office would know (or care), but as the surgeon who did the kyphoplasty surgery, or at least attempted it, so much time was allowed to lapse that the vertebral bone had enough healing so that the kyphoplasty balloons were not able to inflate. In other words, the delay by the insurer changed the vertebral deformity from correctible to not-correctible (i.e., permanent). The patient was permanently damaged by insurer delay. The alignment could have been corrected had the approval been timely.

I really don't know what the purpose of your office is. Over the years, I have submitted multiple complaints, and whatever is the total number submitted, in zero cases was any action taken. Just like in this case, there was some or another excuse.

I am also 100% sure that if anyone in your office, or in the offices of Anthem, or actually any human on the planet for that matter, found that the results of their treatment was compromised by the initial denials and delays of a for-profit insurance company, to result in permanent injury to the involved patient. If LH were your loved one, I am certain you also would feel enraged about how the situation was handled. Even the first peer reviewer on this case agreed that my treatment plan was appropriate, but his hands were tied by the insurer "guidelines." However, apparently for the Office of the Commissioner of Insurance, this situation is called Tuesday.

I plan to publish this letter and your responses, after redacting the patient's personal details, on a webpage I have been creating to document the inordinate and inappropriate control over medical care that is being exercised by insurance companies: **drwolgin.com/insurancedontcare.**

I can only hope that you or someone you love is someday on the receiving end of a similar situation, so you can decide if this level of "quality," where the insurer and not the doctor decides what is appropriate treatment, is good enough for you too.

Sincerely,

Mark Wolgin, MD

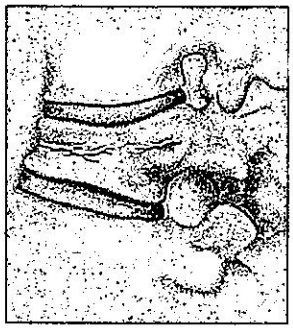
Below is excerpted from the webpage **drwolgin.com/insurancedontcare** regarding this case.

Inappropriate Use of "guidelines:" Case of LH, broken spine

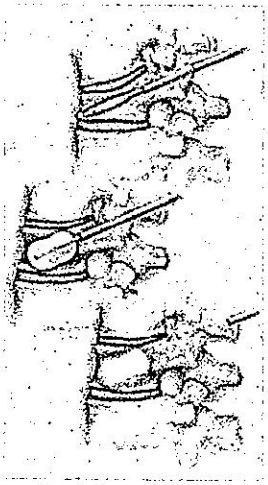
Bottom line/Summary: with details below, due to the actions of the insurer's subcontractor Carelon, hired to "optimize" (i.e., deny) care, due to the denials and delays, this patient not only suffered unnecessarily for a prolonged time, but also had a clinical result that is below community standard, which is essentially insurer-induced malpractice, all of which could have been prevented by timely treatment (blocked by insurer).

Though a spinal bone was involved, the end result is no different than allowing any other fracture to heal in the wrong position, when timely treatment could have prevented a poor outcome. Most frustrating:

The insurer can't be held liable for the negative impacts of their non-justifiable decisions.



Patient LH (MRN 370340, BCBS insurance) was on her riding lawn mower 10/22/23, and a large tree branch weighing about 60 lbs fell on her. With the deforming force on her lumbar spine bending her forward in fraction of a second, she sustained a **compression fracture** of the vertebral body of T12 as noted in this schematic to the right --> (and with her actual X-rays below)



Though not every compression fracture requires surgery, and though the patient did not have any neurological deficit (weakness or sensory changes of the legs or genitals), one of the indications is **intractable pain**. Since the location of the fracture is between the stiff thoracic spine (the spine region stabilized by ribs) and the mobile lumbar spine, practically everything this patient would do would aggravate her pain.

One of the treatment options is a minimally invasive surgery called **kyphoplasty**, with a schematic of this procedure to the left. The patient is put to sleep, and through two small incisions, one on right and one on left, done with X-ray guidance, a needle is placed into the bone, through which a balloon is placed that will increase the height of the compressed bone. The balloon is removed, and then bone cement is placed in this area created by the balloon. This cement looks like toothpaste when it is introduced, but is a quick drying plastic that hardens in about ten minutes. Usually, much of the height is restored, and the patient has immediate relief. Despite the risks, this surgery very often results in a happy patient.

Despite the fact that as a surgeon, I don't sell surgery, and I note that the only guarantee is no guarantee, and that there are risks, LH chose surgery. Even with pain medications, she found the pain intolerable.

Consider the subjective state for a minute of intolerable pain. Though we cannot cure everyone's pain, for this problem, the options are physical therapy (a delay tactic...how much does it help to move your broken bone?), medications, and sometimes bracing. None of these treatments were giving any relief. Now, imagine you had a clamp on your finger, and you couldn't get it off. Do you think you'll be able to get any rest? Can you ignore it? You would likely go to great efforts to get the clamp removed, and for LH, the cause of the pain was right in the middle of her spine.

Appropriately, the patient was offered kyphoplasty, so we submitted the request for the surgery. I'm sure you can guess the answer:

Denied.

We appealed, and I had a chance to speak with their physician reviewer, a neurosurgeon, and explained the situation. At the beginning of the call, he noted that he could not reverse the decision (umm, so why are we talking??). However, **he did also state that he totally agreed with my plan**, but that their particular policy had guidelines which included a "carve out" for spinal trauma. Unbeknownst to me and also apparently to the patient, her husband (whose employer purchased their insurance), the benefits manager, and the branch the husband's city government employer handling benefits, none were informed that the "guidelines" of her insurance plan had a "carve out" (**exclusion for any condition they don't cover**) for spinal trauma.

I asked, since he's on the inside, can he start the appeal process? Get this: No. Not only couldn't he start an appeal, but he directed me to tell the patient to start that process by calling the number on the back of her insurance card. So, yes, here is a patient, LH, in intractable pain, who now gets an opportunity to go through the phone tree and endless time on hold and being shuttled around, and being told that the recommendation for surgery was "not medically necessary," that "the doctor's office had not submitted adequate documentation," that I was both in and out of their network (I am in), and any number of other reasons why the surgery could not be done.

I am not making this s*%# up.

There is a lot to unpack here.

--First, I am reminded again that insurance companies subcontract or outsource the dirty work of saying "no" to patients by hiring companies to do their medical benefits management (MBM). These companies "manage" the care with one common theme: delay or deny as much as possible. Like a mafia Don hiring out the dirty work to a hit man, insurers hire these MBM companies to say "no." Just

to clear up any confusion, since I have been in practice since '93, never once has an insurer had a suggestion to actually help a patient. Like a one year old, they have learned the power of saying "no," and by definition, **literally could not care less about the patient.** For this case BCBS uses a company called **Carelon** to do the dirty work of the (inappropriate) denial. (I mentioned above about how an insurance company Ambetter who does their best to deny everything. Ambetter uses a company called **Turning Point**, and with their **criteria here**, since any submitted medical records have to meet **all their criteria**, they literally can deny every case.)

–If the case reviewer spinal surgeon can't apply common sense medical judgment to a clinical situation, and approve a treatment, why was I even talking to him? Unless proven otherwise, the insurer was paying a surgeon to tarnish his own MD credentials to read to me the inappropriate medical decision making.

–If they have a carve out or exclusion for spinal trauma, how was the patient supposed to know this detail? Was the purchaser of the insurance plan (the patient's husband's employer) made aware of this deficiency in coverage when they decided which plan to purchase? Did they say to their employees that they have great coverage, but just don't break your back!! I'm sure that tucked into the fine print was language noting that they would follow guidelines, but which patients know what conditions they will get, or have the bandwidth to ask for an research the guidelines? And would Carelon even give them out? **I have asked, and they would not share them with me, and I speak medical!**

--How is the failure to disclose gaps in medical coverage not deceptive marketing?

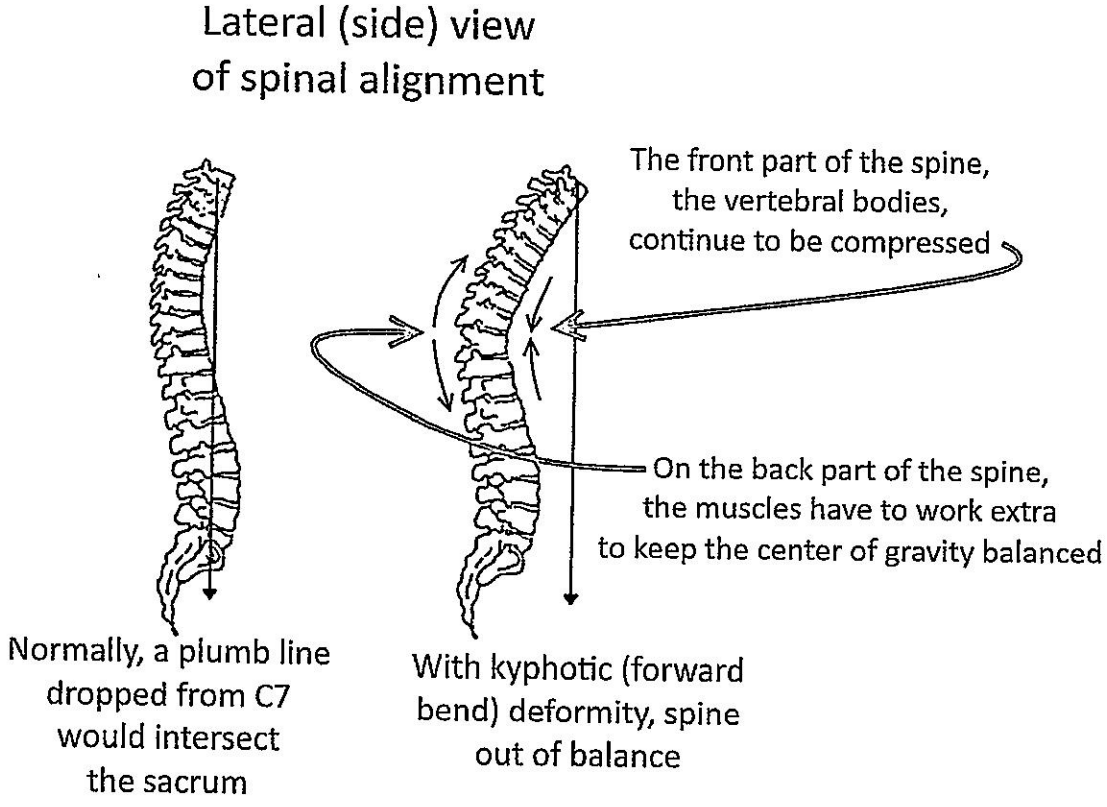
–The neurosurgeon reviewer referred to the word "guideline," but **even that word is a lie**. Since apparently, the application of medical judgment is prohibited to get past the guidelines, and since the insurer has de facto control of medical care and is practicing medicine without a license, a more appropriate word would be the "laws" of medicine.

–How is it appropriate that the patient start the appeal process, when she is not medically sophisticated, and in intractable pain? Could the insurer be more obstructive? Would they think this recommendation would be appropriate if LH were their sister or mother? Does the insurer have more information than I do, given that I am not only seeing the patient in front of me, but have to be held to a community standard of care? **Again, could the insurer care any less**? Time being of the essence? They couldn't care less. How is this activity not illegal?

Wait, there is more to the story.

One of the issues with compression fractures at the thoracolumbar junction of the spine is that the alignment of the spine changes...**for the worse.** When viewed from the side, the center of gravity of most people is over their hips. If you put a

bend in the spine, the center of gravity moves forward, basically putting the patient at risk of a lifetime of pain from the backside (posterior) muscles working harder and overtime to keep the patient upright, to correct what is/was, when treated properly, a correctible problem. However, with the care being denied by their MBM Carelon, the for-profit insurance company demonstrates their conflict of interest, **with their priority being on preventing medical care.**



During the time that the patient's surgery was denied, she did in fact become more deformed (kyphotic = increased forward bend) at the T12 segment. This deformity could have been avoided or at least mitigated.

When the patient returned in December with the increased forward bend, kyphosis, we requested the surgery again, and again, surprise!!...**it was denied.** I asked our surgery scheduler to demand an expedited escalation of this case to a practicing spine surgeon.

I had on 12/19/23 a chance to do a peer to peer with Dr. AC, neurosurgeon, for Carelon MBM. First I had to assure whether he had the ability to apply common sense or could change the denial and initially he did not answer. He noted that the previous denial was because the patient had not had 6 weeks of therapy. Since the option for actual appropriate care was in the hands of this reviewer, I did not want to argue, but **the six week delay was not the reason given to me**, nor has LH been able to tolerate any therapy.

Simply, the insurer delayed any care for an additional six weeks (of patient suffering). I related that that history was not the reason given to me for the denial but that the plan had **an exclusion** for trauma. Either way, I explained the situation and we were able to get an authorization number.

Should I be thanking the heavens that I as a spine surgeon can actually help a patient with spine surgery? Apparently, yes. The rules have changed.

But wait a minute: The plan has a carve out for spinal trauma, but now they are approving a case for spinal trauma? **How is this delay not purely bad faith?**

I shouldn't have to be doing this, but I left this comment in the medical record of LH: **"I also have to state for the record here in case there is any third party review, the delay by the insurance company was excessive, inappropriate, and caused unnecessary suffering. I strongly believe that if any of the personnel from the insurance company were subjected to this standard of delay and obstruction, they would find it unacceptable and would agree with my opinion. Clearly, profit over patient for the insurance company."**

For the record, officially, the stance of the insurer is "Doctor, you can do whatever you want, but we're just not going to pay for it." Convenient for them.

Since the patient had thought she was covered with health insurance, to cover any issues that arise with her health, and since there is no way she could have predicted that she would either have a spinal fracture, or that her insurer would not cover this particular procedure, this action by the insurer, in my opinion again, reeks of bad faith, with some additional info from this link to a law firm that works in GA to provide some clarity. Also, again my opinion, not disclosing to their insurance clients that this insurance product doesn't cover things like a broken back is a detail that reeks of deceptive marketing practices. I suspect that the insurer is technically covered, as in the reams of fine print that any potential customer either signs or doesn't get insurance, there is language to cover their actions with vague terms written in favor of the insurer, but **the spirit of the agreement is immoral**.

Much like before 9/11, nobody would ever think that jet airplanes are actually bombs, why would LH think that her insurance wouldn't cover her for a broken back?