

**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. 149866-001**

**Blue Cross Blue Shield of Michigan,**

**Respondent.**

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**Issued and entered**  
**this 2<sup>nd</sup> day of November 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) was denied coverage for back pain treatment by his health plan, Blue Cross Blue Shield of Michigan (BCBSM).

On September 16, 2015, the Petitioner filed a request with the Director of Insurance and Financial Services seeking an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits under an individual policy underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. After a preliminary review of the material, the Director accepted the Petitioner's request on September 23, 2015.

Because the case involved medical issues, the Director assigned it to an independent review organization which provided its analysis and recommendation on October 16, 2015.

**II. FACTUAL BACKGROUND**

At the time the Petitioner received the services in dispute in this case, his health care benefits were defined in BCBSM's *Keep Fit and Member Edge Individual Market Certificate*<sup>1</sup>

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<sup>1</sup> BCBSM form no. 351D, approved 10/12.

(the certificate). That coverage was effective on March 15, 2013, and included a 180-day waiting period for pre-existing conditions.

On April 11 and April 25, 2013, the Petitioner was treated for back pain at [REDACTED] [REDACTED] Claims totaling \$17,805.06 were submitted to BCBSM.

BCBSM denied coverage, saying the services were for treatment of a pre-existing condition and therefore not a benefit. The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination on July 17, 2015, affirming its coverage denial. 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 treatment for back pain in 2013?

### IV. ANALYSIS

#### Respondent's Argument

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

. . . After careful review, I confirmed our denial is appropriate and must be maintained. Your health care Plan does not cover services for pre-existing conditions during the first 180 days of your coverage. Therefore, we cannot honor your request to cover the services reported to treat your preexisting condition, and you remain responsible for the billed charges.

At the time services were rendered, you were covered under the *Keep Fit and Member Edge Individual Market Certificate*. Page 1.6, (*Section 1: Information About Your Contract*), explains that services for pre-existing conditions are not covered during the first 180 days of your coverage. All covered services and benefits are subject to a 180-day waiting period for pre-existing conditions. The 180-day waiting period begins on the first day your coverage becomes effective.

Page 8.25, (*Section 8: The Language of Health Care*), defines a pre-existing condition as a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date. Therefore, if you received treatment or medical advice for a particular condition 180 days before enrolling in your BCBSM plan, that condition would be considered a pre-existing condition subject to the 180-day waiting period explained above.

To ensure all consideration was given to you, a board-certified M.D. in Internal Medicine reviewed your professional claims and a board-certified D.O. in Internal

Medicine reviewed your facility claims, along with your appeal, and your health care plan benefits for Blue Cross Blue Shield of Michigan.

\* \* \*

Based on the medical consultants' determination that you had a pre-existing condition (back pain), together with the terms of your coverage stating that services for pre-existing conditions are not payable for the first 180 days of your coverage, we must maintain our denial.

### Petitioner's Argument

The Petitioner included with his external review request a letter to BCBSM dated September 1, 2015, in which he explained his grievance:

It is my understanding based on your notification of refusal of services dated 4-11-13 and 4-25-13 that this procedure has been denied because (it was a pre-existing condition).

As you know I had an MRI on 9-13-12 because my [doctor] wanted to see why my back was hurting; my results were arthritis and disc space narrowing. He did not order any more test or prescribe any medication for it. I just have to deal with pain like millions of other people.

On 3-13-13 we had to switch our ins[urance]. Between the dates of my MRI and switching ins[urance], I had no treatment for back pain. As you can see that's six months no doctor's appointments for pain.

What I did do, was some work using my skid steer to clean-up some curb lines and other things; as I was cleaning the curb line I ran into it hard and messed up my back. . . . I tried to cope with the pain but it was not going away so I finally went to the doctors on 3-20-13 a week later. That is when [my doctor] told me to see . . . the pain clinic for shots. This was a new injury caused by running into the curb. I needed to do something so I could continue to work and make a living. Because I had an MRI the Doctor went off that. Yes I've had back pain but that is not why I went for the shots, in the years I've dealt with pain I never once went to get shots. Just because the incident happened during the 180 days for the new insurance I should not have to pay this bill, you should not penalize me for a new injury. This is not pre-existing.

### Director's Review

In 2013 BCBSM was a nonprofit health care corporation, governed by the Nonprofit Health Care Corporation Reform Act (NHCCRA), MCL 550.1101 *et seq.* The NHCCRA

allowed BCBSM to include a pre-existing condition waiting period in its individual (i.e., nongroup) health plan certificates.<sup>2</sup> Section 402b(1) of the NHCCRA, MCL 550.1402b(1), says:

For an individual covered under a nongroup certificate . . . a health care corporation may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the certificate.

A pre-existing condition waiting period that substantially conforms to section 402b(1) was included in the certificate. That provision says (p. 1.6):

Most benefits are available on the effective date of your contract. However, services for pre-existing conditions are not covered during the first 180 days of your coverage, beginning on the effective date. . . .

**NOTE:** Unless noted otherwise, all covered services and benefits are subject to a 180-day waiting period for pre-existing conditions. The 180-day waiting period begins on the first day your coverage becomes effective, not on the date your application was submitted.

The certificate's definition of "pre-existing condition" is nearly identical to section 402b(1): "A condition for which medical advice, diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date."

On April 11 and April 25, 2013, the Petitioner was treated for back pain. That care came during the waiting period, "the first 180 days of . . . coverage, beginning on the effective date." The Petitioner's coverage was effective March 15, 2013, so the waiting period extended 180 days to September 11, 2013.<sup>3</sup>

The back pain treatment in April 2013 would not be covered if it was shown to be related to "a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date" (the "look back" period). According to BCBSM, the Petitioner's enrollment date<sup>4</sup> was February 28, 2013, so the look back period was the 180 days from September 1, 2012, to February 28, 2013.

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<sup>2</sup> Waiting periods for pre-existing conditions were allowed in 2013 but are no longer permitted in most plans.

<sup>3</sup> Section 402b(1) says "6 months" and the certificate says "180 days." While nearly the same, the Director will use 180 days because in this case it is more favorable to the Petitioner.

<sup>4</sup> The certificate (p. 8.12) defines "enrollment date" as "the date the subscriber submits a substantially complete application for coverage to BCBSM."

It is BCBSM's contention that the Petitioner's pain treatment in April 2013 was not covered because it was related to a pre-existing condition for which he had received treatment (e.g., an MRI of the spine on September 13, 2012) during the look back period.

The question of whether the medical services the Petitioner received in April 2013 were treatment of a pre-existing condition was presented to an independent review organization (IRO) for analysis, 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 orthopedic surgery, fellowship trained in spine surgery, and has been in active practice for more than 18 years. The IRO report provided the following analysis and recommendation:

This case concerns a 52 year-old male who has requested coverage for the services he received on 4/11/13 and 4/25/13. The Health Plan denied this request on the basis that these services were for treatment of a pre-existing condition.

\* \* \*

The Health Plan indicated that these services were for treatment of a pre-existing condition. The Health Plan explained that records dated 3/20/13 indicate that the member has had back pain since 2004. The Health Plan also explained that the member had an MRI of the spine for back pain in September 2012, which showed disc bulging and narrowing of the central canal, among other findings. The Health Plan further explained that medical records dated 4/11/14 indicated that the member had "been experiencing this pain for 10 years." The Health Plan's Certificate of Coverage was included in the case file.

**Recommended Decision:**

The MAXIMUS physician consultant determined that the services that the member received on 4/11/13 and 4/25/13 were for treatment of a pre-existing condition.

**Rationale:**

The MAXIMUS independent physician consultant, who is familiar with the medical management of patients with the member's condition, has examined the medical record and the arguments presented by the parties.

The results of the consultant's review indicate that this case involves a [REDACTED] year-old male who has a history of back pain. At issue in this appeal is whether the services that the member received on 4/11/13 and 4/25/13 were for treatment of a pre-existing condition.

The MAXIMUS physician consultant explained that the medical records provided for review indicate that the member had pre-existing degenerative changes of disc

degeneration in the lumbar spine. The MRI from 2012 clearly shows multiple levels of degenerative disc condition and degenerative spinal changes. The physician consultant indicated that the member has degenerative back pain problems. The consultant explained that the member's medical records clearly show that the degenerative condition was present in 2012.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the services that the member received on 4/11/13 and 4/25/13 were for treatment of a pre-existing condition.

The Director is not required to accept the IRO's recommendation. 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 experience, expertise, and professional judgment. In addition, the IRO's recommendation is not contrary to any provision of the Petitioner's certificate of coverage. See MCL 550.1911(15).

The Director, discerning no reason why the IRO's recommendation should be rejected, finds that the back pain treatment rendered on April 11 and April 13, 2015, was treatment of a pre-existing condition and is therefore not a covered benefit.

#### V. ORDER

The Director upholds BCBSM Insurance Company's July 17, 2015 final adverse determination.

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:



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Randall S. Gregg  
Special Deputy Director