

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. 145110-001

Golden Rule Insurance Company,

Respondent,

Issued and entered
this 9th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 26, 2014, ██████████, authorized representative of his adult son ██████████ (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 (PRIRA), MCL 550.1901 *et seq.*

The Petitioner receives health care benefits as a dependent under an individual plan¹ underwritten by Golden Rule Insurance Company (Golden Rule). The Director notified Golden Rule of the external review request and asked for the information it used to make its final adverse determination. Golden Rule furnished the requested information on December 3, 2014. After a preliminary review of the material received, the Director accepted the Petitioner's request on December 8, 2014.

Because the case involves medical issues, the Director assigned it to an independent medical review organization, which provided its analysis and recommendation to the Director on December 22, 2014.

¹ The individual coverage was obtained through membership in the Federation of American Consumers and Travelers (FACT). FACT is the policyholder and the coverage is sometimes called "association group" coverage.

II. FACTUAL BACKGROUND

The Petitioner's benefits are described in a certificate of insurance (the certificate) issued by Golden Rule. The coverage was effective on August 1, 2012.

On August 1 - 2, 2012, the Petitioner received emergency room care at [REDACTED] - [REDACTED], a network provider, after he experienced a headache and visual disturbances. He was examined by a physician who recommended he have magnetic resonance imaging (MRI) and a neurology consultation. The providers' charge for this care was \$6,645.00; Golden Rule's re-priced amount was \$3,076.84.²

Golden Rule provided this care under the emergency services provisions of the certificate, applying \$100.00 of the re-priced amount to the emergency room deductible and \$2,976.84 to the Petitioner's unmet \$5,000.00 network provider deductible. This left the Petitioner responsible out-of-pocket for the entire re-priced amount.

The Petitioner appealed Golden Rule's benefit determination through its internal appeals process. At the conclusion of that process, Golden Rule affirmed its decision in its final adverse determination dated November 17, 2014. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did Golden Rule correctly process the claims for the Petitioner's emergency room care?

IV. ANALYSIS

Petitioner's Argument

The Petitioner contends that the need for emergency room care arose from an accident, not an illness, and therefore should be covered under the certificate's provision for "supplemental accident expense benefits," benefits not subject to a deductible.

In an October 6, 2014, letter submitted with the external review request, the Petitioner's father said:

This letter is being written in explaining why this medical bill must be covered by insurance. Initially, the hospital visit was billed as an ILLNESS which our policy denied. This is in fact incorrect. This was an ACCIDENT.

On August 1, 2012 our son . . . experienced visual disturbances and loss of vision

² The re-priced amount is the fee negotiated with network providers.

for upwards of 2 minutes. We contacted our pediatrician (after being unable to get a hold of the dermatologist). We questioned whether [his] new prescription of Accutane might be a correlation. The pediatrician advised us to go directly to the emergency room immediately.

After seeing the E.R. physician, he advised a M.R.I and a neurologist consultation due to [the Petitioner's] symptoms and family history (maternal aunt had brain cancer at 33 years old and paternal grandfather had a brain aneurysm at 39 years old).

With a negative M.R.I and a consultation from the neurologist, . . . [he] was discharged from the hospital. [The neurologist] was unable to determine if it was completely related to the Accutane but advised us to discontinue . . . [The neurologist] mentioned loss of vision can sometime be the result of a migraine. [The Petitioner] has no history of migraines.

After then following up with the dermatologist, . . . he decided NOT to restart [the Petitioner] on the Accutane. To this day, 10/6/2014, [REDACTED] has NEVER had a migraine or experiences any vision loss.

As you can see, this is certainly NOT related to an illness which the insurance company claims. This was an accidental adverse reaction to medication.

Per the contraindications and warning on the Accutane insert, it clearly states: Vision problems. May affect your ability to see in the dark. This condition usually clears up after you stop taking Accutane, BUT IT MAY BE PERMANENT. Other serious eye effects can occur. Stop taking Accutane and call your doctor right away if you have any problems with your vision.

The definition of an accident per Webster's dictionary is: A happening that is not expected, foreseen, or intended.

The definition of an injury per Webster's dictionary is: Physical harm or damage to a person, property, etc...

The definition of Damage per Webster's dictionary is: Injury or harm to a person or thing, resulting in a loss in soundness or value

The Petitioner's believes the services should be covered under the accidental expense benefit rather than as emergency services.

Respondent's Argument

In its final adverse determination, Golden Rule wrote explained to the Petitioner's father:

Your letter indicates you believe the services rendered to [the Petitioner] were for an accident. Therefore, you are requesting the expenses be reconsidered for reim-

bursment under the Supplement Accident Expense Benefits (SAB) provision included in your Certificate of Insurance.

* * *

The submitted information was reviewed by a doctor, Licensed Board Certified in Family Medicine, and who currently practices emergency medicine. The doctor indicates in this case, the services were required to evaluate and manage symptoms that [the Petitioner's] physician(s) felt were due to a migraine. Based on the provided information, it was the doctor's opinion that the services in question were not provided as treatment for an injury as defined by the certificate.

On November 10, 2014, a panel comprised of persons not previously involved in the original benefit determination, was held to review your request. Taking into consideration the doctor's opinion, it was the decision of the reviewing panel to uphold the original benefits applied to [REDACTED] services from August 1, 2012, through August 2, 2012. The services are not eligible for reimbursement under the SAB provision as they were not rendered for an injury as defined by your certificate.

Director's Review

Emergency room care for an illness is subject to both the emergency room deductible and the network provider deductible according to the certificate. But under the certificate's supplemental accident expense benefits provision, care needed to treat an accidental injury is not subject to a deductible unless the covered expenses exceed \$10,000.00. Supplemental accident expense benefits are defined in the certificate (p. 31):

As a supplemental benefit, we will pay up to \$10,000 in first dollar coverage [*i.e., no deductible or other cost sharing*] for the covered expenses shown in the Medical Expense Benefits provision which:

- (A) result from any one accident which causes injury to a covered person;
and
- (B) are incurred within 90 days after the injury.

The covered person's insurance must have been in force on the date of the injury to receive benefits under this provision.

If the amount actually incurred exceeds \$10,000, only then will any applicable deductible or coinsurance percentage be applied to the remaining covered expenses.

The certificate (p. 8) says "injury" means

accidental bodily damage sustained by a covered person. All injuries due to the same accident are deemed to be one injury.

The Petitioner contends that the emergency services were needed because of an accident, an adverse reaction to the drug Accutane. Golden Rule says the services were needed to treat an illness. To help resolve that issue, the Director assigned the case to an independent review organization (IRO) for analysis as required by section 11(6) of the PRIRA, MCL 550.1911(6).

The IRO physician reviewer is certified by the American Board of Emergency Medicine and in active clinical practice. The IRO report contained this analysis and recommendation:

Reviewer's Decision and Principal Reasons for the Decision:

It is the determination of this reviewer that the medical services received in the Emergency Department from August 1, 2012 through August 2, 2012 were provided for an illness.

Clinical Rationale for the Decision:

The enrollee's symptoms were due to a complicated migraine. Even if they did not know that at the time of presentation and thought that his symptoms were from Accutane, an adverse medication reaction is not an injury.

Vision loss not caused by trauma can be due to vascular occlusion, retinal detachment, vitreous hemorrhage, macular disorders, and neuro-ophthalmologic disease. His treatment with a normal examination, lab work, MRI/MRA of the brain, observation, and Neurology consultation is in line with the current standard of care. The enrollee presented to the ER with transient vision loss that lasted for a couple of minutes and then a headache. He did not suffer any type of trauma. According to Rosen's Emergency Medicine Concepts and Clinical Practice textbook, an injury is a "harmful event caused by the acute transfer of energy to a patient that results in tissue and/or organ damage." What this typically means is that the enrollee suffers some kind of trauma causing bodily damage. In this case, the enrollee's symptoms were due to a complicated migraine. Based on the documentation submitted for review, it is clear that the enrollee had a complicated migraine, which is considered an illness and not an injury.

Recommendation:

It is the recommendation of this reviewer that the denial issued by Golden Rule Insurance Company for the medical services received in the Emergency Department from August 1, 2012 through August 2, 2012 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 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 recommendation is based on extensive experience, expertise, and professional judgment. Furthermore, it 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 Golden Rule correctly processed the claims for the Petitioner’s emergency room care in accord with the terms of the certificate.

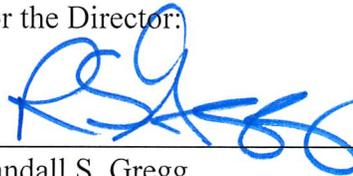
V. ORDER

The Director upholds Golden Rule Insurance Company’s final November 17, 2014 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.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director