

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. 146109-001

Priority Health Insurance Company
Respondent

Issued and entered
this 6th day of March 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 3, 2015, ██████████ (Petitioner) filed a request for external review with the Director of Insurance and Financial Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits under an individual policy issued by Priority Health Insurance Company. The benefits are defined in Priority Health's *MyPriority Short-term PPO Insurance Policy* (the policy). His coverage under the policy became effective on October 21, 2014.

The Director notified Priority Health of the external review and requested the information used to make its final adverse determination. Priority Health furnished information for the review on February 3, 2015 and February 10, 2015. After a preliminary review of the material, the Director accepted the Petitioner's request for external review on February 10, 2015.

Because medical issues are involved, the Director assigned the case to an independent review organization which provided its analysis and recommendation on February 24, 2015.

II. FACTUAL BACKGROUND

The Petitioner is a 43 year old male with a history of pain in the lower left quadrant of his abdomen. Beginning in April 2014, he had a series of appointments at which he was examined

for his pain by a physician assistant, a nurse practitioner, and a physician. On October 3, 2014, a physician recommended the Petitioner have an abdominal CT scan to determine whether he had a hernia. The Petitioner had the CT scan on October 30, 2014. The presence of an inguinal hernia was confirmed and the Petitioner had surgery on December 29, 2014.

The Petitioner submitted claims to Priority Health for the October 30 CT scan and the surgery. Priority Health initially paid the October 30 claim but later ruled that the claim should not be paid because the hernia was a medical condition that existed before the Petitioner's coverage began. Coverage for the December 29 surgery was also denied.

Priority Health denied coverage ruling, the surgery and related medical services were treatment of a pre-existing condition and that treatment for an inguinal hernia is excluded under the policy.

The Petitioner appealed the denials through Priority Health's internal grievance process. At the conclusion of that process, on January 15, 2015, Priority Health issued a final adverse determination affirming its coverage denial. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did Priority Health correctly deny coverage for the Petitioner's October 30 and December 29, 2014 claims?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination Priority Health wrote:

Medical records dated April 21, May 5, and June 11, 2014, indicate [Petitioner] was being evaluated due to left lower quadrant abdominal pain. The medical record dated June 11, 2014, from [REDACTED] states, "Recommend referral to general surgery next for possible hernia which was been difficult to detect on exam." Additionally, medical records dated October 3, 2014, from [REDACTED] indicate either a computed tomography (CT) scan or diagnostic laparoscopy would be necessary to further identify the cause of the abdominal pain. While the correct diagnosis had not been reached at this point, treatment for the condition had already begun. Priority Health Insurance Company appropriately denied the claims billed with diagnoses of "unilateral or Unspecified Inguinal Hernia", "Bilateral Inguinal Hernia" and "Abdominal Pain" as a pre-

existing condition in accordance with the Insurance Policy and Schedule of Benefits.

The Appeal Committee recognizes that the services [Petitioner] is requesting coverage for are medically necessary, however, because these symptoms began prior to the effective date of the policy, services for that condition will not be covered. The policy does not focus on the date a diagnosis was made, but that there has been either medical advice, diagnosis, care **OR** treatment recommended or received from a health professional five years prior to the effective date. Those facts are met in [Petitioner's] case.

In addition, the Committee noted that even if the condition were not clearly pre-existing, it would fail to be covered under the policy that this member has...

Surgical treatment of inguinal hernia is excluded from coverage in accordance with the *MyPriority Short-term PPO Insurance Policy* which states [in section IV(A), page 14]:

Physician's fees and other related charges for certain surgeries and treatments performed on an outpatient or inpatient basis are not Covered. These include but are not limited to:

* * *

(p) Surgical treatment of inguinal hernia (other than strangulated or incarcerated)

Petitioner's Argument

In his request for an external review, the Petitioner wrote:

According to Wikipedia typically medical advice involves giving a diagnosis and or prescribing a treatment for a medical condition.

Up until now [presumably, October 30, 2014 when the CT confirmed the hernia] I was not diagnosed with a hernia. I was not given any medical advice regarding a hernia. I was not given any medical treatment for a hernia. The only thing that I was assessed for was unspecified abdominal pain with no etiology. Basically my discomfort could have been anything from digestive, ulcer, colon, diverticulitis, prostate, etc. How does Priority Health say specifically that a hernia was a pre-existing condition from all those visits.

I don't know how Priority Health can state that treatment for the condition had already begun when the hernia wasn't identified yet. Please read my treatments for each visit and you will see that there was no advice, treatment or diagnosis for a hernia.

According to WebMD the only treatment for an inguinal hernia is surgery.

The Petitioner submitted a document explaining his medical visits in detail.

Director's Review

The Petitioner is covered under a short-term health benefit policy. The Petitioner was denied coverage for services the insurer concluded involved a pre-existing condition excluded from coverage under the policy. The following provisions in that policy govern pre-existing conditions:

SECTION 1. About This Policy

This is a nonrenewable Policy. This plan is not intended to be of a permanent nature and does not cover Pre-Existing Conditions. See Section 6 of this Policy.

[Page 4]

SECTION 6. Limitations

* * *

A. Pre-Existing Condition Exclusion

Benefits will be excluded under this Policy for each Illness or Injury or condition for which, during the five year period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs....

[Page 29]

SECTION 16. Definitions

* * *

(52) Pre-Existing Condition. An Illness, Injury or condition not disclosed on your application, for which, during the six month period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, "treatment" includes the use of prescription drugs....

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Two questions were presented by the Director 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):

1. Did the Petitioner's claims involve the receipt of medical advice, diagnosis, care, or treatment of a pre-existing condition?
2. Did the Petitioner's claims involve the treatment of a type of hernia excluded from coverage under the Petitioner's policy,?

The IRO reviewer is a licensed physician in active clinical practice who is board certified in surgery and critical care, and has been in active practice for more than 20 years. The IRO reviewer provided the following analysis and recommendation:

The member's insurance coverage took effect in October 2014. The member had been seen several times since April 2014 for left lower quadrant abdominal pain. At a point prior to his insurance coverage being in effect, the member was recommended to see a surgeon for evaluation. The member eventually [on October 30, 2014] had a CT scan, which demonstrated a hernia and he underwent repair. The Health Plan's contract defines a pre-existing condition as "An Illness, Injury for which, during the five year period prior to your effective date, medical advice, diagnosis, care or treatment was recommended by or received from a Health Professional. For purposes of this limitation, 'treatment' includes the use of prescription drugs. Genetic information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to the genetic information." (Page 44.)

[T]he member sought care for a condition which was ultimately shown to be a hernia before his insurance coverage was in effect. Therefore...this condition falls under the Health Plan's definition of a pre-existing condition. The Health Plan's contract also specifically excludes coverage for surgery for non-incarcerated, non-strangulated hernias...[T]he operative note clearly provides a diagnosis of reducible hernia. Therefore...the herniae were neither incarcerated nor strangulated.

Pursuant to the information set forth above and available documentation...the services at issue in this appeal were for treatment of a pre-existing condition and these services were for treatment of an inguinal hernia and not a strangulated or incarcerated hernia.

The Director is not required in all instances 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 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. See MCL 550.1911(15).

The Director can discern no reason why the IRO's analysis should be rejected in this case. The Director finds that Priority Health's denial of coverage for the Petitioner's surgery and related medical services provided on October 30 and December 29, 2014 is consistent with the terms and limitations of the Petitioner's policy.

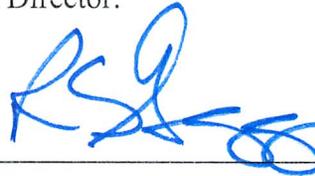
V. ORDER

The Director upholds Priority Health Insurance Company's January 15, 2015, final adverse determination. Priority Health is not required to provide coverage for the medical services the Petitioner received on October 30 and December 29, 2014.

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