

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

v

File No. 102684-001

World Insurance Company  
Respondent

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Issued and entered  
this 16<sup>th</sup> day of March 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**

**PROCEDURAL BACKGROUND**

On January 28, 2009, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on February 5, 2008.

The Commissioner notified World Insurance Company (World) of the external review and requested the information used in making its adverse determination. The information was received on January 30, 2009.

The case presented a medical question so the Commissioner assigned it to an independent review organization, which provided its analysis to the Commissioner on February 19, 2009.

**II**

**FACTUAL BACKGROUND**

The Petitioner has health care coverage as an eligible dependent under an individually unwritten major medical certificate from World. Her benefits and coverage are defined in the

certificate. Her coverage was effective August 1, 2008.

On August 21, 2008, the Petitioner saw a pediatric urologist and on October 14, 2008, she underwent surgery for kidney problems (“right upper pole heminephrourectomy with removal of the upper pole moiety ureter”). According to the explanation of benefits forms in the record, the total charge for this care was \$19,433.70. World denied coverage on the basis that it was related to a pre-existing condition.

The Petitioner appealed World’s denial. After exhausting World’s internal grievance process, the Petitioner received a final adverse determination dated December 9, 2008.

### **III ISSUE**

Was World Insurance Company correct in denying coverage for the Petitioner’s office visit and surgery?

### **IV ANALYSIS**

#### **Petitioner’s Argument**

The Petitioner’s mother says the paperwork for the World coverage was filled out in June 2008 and then the Petitioner got sick in July 2008. She also says that she received notice from World on October 1, 2008, that the surgery was approved but misplaced the letter.

The Petitioner’s mother further says that the World certificate has a \$5,800.00 deductible and that \$5,100.00 has already been paid. She wants World to cover the services her daughter received in August and October 2008 saying, “We just want the World Insurance Co, to pay their fair share.”

#### **Respondent’s Argument**

World asserts that its denial of coverage was correct because the Petitioner’s certificate excludes coverage for medical services that are related to pre-existing conditions. The certificate’s “General Exclusions and Limitations” section contains this provision:

*This certificate does not cover:*

\* \* \*

**Pre-Existing Conditions**

Pre-Existing Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the application and not excluded from coverage by name or specific description are covered, subject to the provisions of this certificate.

A “Pre-Existing Condition” is a condition:

- a. For which medical advice was given or treatment was recommended by a physician or received from a physician within a six-month period prior to the Certificate Effective Date of coverage for that covered person, or
- b. Which produced symptoms within a six-month period prior to the Certificate Effective Date of coverage for that covered person.

World said in its final adverse determination that the Petitioner sought medical services related to her kidney problem within the six months prior to her effective date of coverage on August 1, 2008:

[The Petitioner’s] medical records were reviewed by the grievance review panel. The Medical Imaging Report lists the service date as July 28, 2008. It also notes that on July 31, 2008, the [Petitioner’s] mother was notified of the test results and referred to the pediatric urologist. Since symptoms began and were examined prior to the effective date of the certificate, our decision in determining this condition to be pre-existing is upheld.

Commissioner’s Review

The Commissioner first notes that a provision limiting coverage for pre-existing conditions is permissible in an individual health insurance certificate. Section 3406f of the Insurance Code of 1956 (MCL 500.3406f) says in part:

- (1) An insurer may exclude or limit coverage for a condition as follows:
  - (a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), 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 12 months after the effective date of the policy or certificate.

To answer the question of whether the care the Petitioner received in August and October 2008 was related to a condition “for which medical advice, diagnosis, care, or treatment was

recommended or received” within the six months prior to August 1, 2008, the Commissioner requested an analysis and recommendation from an independent review organization (IRO). The IRO expert reviewing this case is a board-certified urologist who has been in practice for more than ten years. The IRO report said:

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

\* \* \*

The MAXIMUS physician consultant noted that the record from the [Petitioner’s] 7/23/08 office visit stated “during the last couple of months she had 2 attacks of urinary tract infection. She has had right-sided abdominal pain, mostly in the upper abdomen.” The MAXIMUS physician consultant also noted that the [Petitioner] underwent a CT scan on 7/18/08, which revealed a cyst in the upper pole of the kidney. The MAXIMUS physician consultant further noted that the plan was to obtain further imaging with an intravenous pyelogram, and that the [Petitioner] might need a referral to a pediatric urologist. The MAXIMUS physician consultant explained that the [Petitioner’s] symptoms were present for a couple of months prior to her July 2008 office visit.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the services that [the Petitioner] received in August 2008 and October 2008 were for treatment of a pre-existing condition.

The Commissioner is not required in all instances to accept the IRO’s recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite “the principal reason or reasons why the commissioner 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. The Commissioner can discern no reason why that judgment should be rejected in the present case.

The Commissioner accepts the conclusion of the IRO and finds that the Petitioner’s services in August and October 2008 were for a pre-existing condition and therefore are not covered benefits.

**V  
ORDER**

The Commissioner upholds World Insurance Company's final adverse determination of December 9, 2008. The company is not required to provide coverage for the Petitioner's office visit and surgery in August and October 2008.

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 sixty 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.