

**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

File No. 105366-001

v

UniCare Life & Health Insurance Company  
Respondent

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Issued and entered  
this 20<sup>th</sup> day of September 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On June 3, 2009, 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on June 10, 2009.

The case required a review by a medical expert. Therefore, the Commissioner assigned the matter to an independent review organization which submitted its recommendation to the Commissioner on August 5, 2009.

**II**  
**FACTUAL BACKGROUND**

The Petitioner receives benefits under an individual health care plan underwritten by UniCare Life & Health Insurance Company (UniCare). Her coverage was effective November 1, 2008.

The Petitioner received services at the Henry Ford Fairlane Medical Center on January 8, 2009. According to UniCare, the charge for these services was \$3,375.00. UniCare denied coverage, saying the services were related to a pre-existing condition and therefore not a covered benefit under the terms of the Petitioner's plan.

The Petitioner appealed. After completing UniCare's internal grievance process, the Petitioner received a final adverse determination dated April 27, 2009, upholding the denial. The Petitioner now seeks review under PRIRA.

### **III ISSUE**

Was UniCare correct in denying coverage for the Petitioner's care on January 8, 2009?

### **IV ANALYSIS**

#### Petitioner's Argument

The Petitioner, in her request for external review, related her reasons for going to the XXXXX on January 8, 2009:

The purpose of the visit was due to a serious life-threatening medical condition. While [in] Europe, I was sexually assaulted and needed to be examined.

My health was in jeopardy because I have a history of a deep vein thrombosis and a pulmonary embolism. This was a life and death matter, which I do not find pre-existing because the treatment was necessary to stabilize my life....

The Petitioner believes the care she received should be covered by UniCare. She wants the adverse determination reversed.

#### Respondent's Argument

In its final adverse determination, UniCare told the Petitioner its reason for denying coverage:

Services related to a pre-existing condition are excluded under the plan for twelve months after the effective date. Clinical records...indicate that you were treated on October 07, 2008, due to chest wall pain and hematoma.

As such, no expenses for treatment related to chest pain, including prescriptions, are eligible for benefit consideration until after November 1, 2009.

UniCare believes that it correctly denied the Petitioner's claim.

### Commissioner's Review

The Petitioner's health plan excludes coverage for pre-existing conditions for the first twelve months. The exclusion says (pp. 37-39):

#### ***Excluded Services***

In addition to any other exclusions and limitations described in this Plan, the Plan does not provide benefits for:

\* \* \*

- Any services received on or within 12 months after the Effective Date of coverage if they are related to a **Pre-existing Condition** as defined in the Definitions section.

"Pre-existing Condition" is defined in the plan (p. 14) as

a disease or physical condition for which medical advice, diagnosis, care or treatment was recommended or received by the Insured Person during the 6 months before the Effective Date of the Insurer Person's coverage.

Pre-existing condition limitations in individual health care plans are permitted under Section 3406f(1)(a) of the Insurance Code of 1956, MCL 500.3406f(1)(a):

- (1) An insurer may exclude or limit coverage for a condition as follows:
  - (a) For an individual covered under an individual policy or certificate..., 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.

Under PRIRA, the Commissioner seeks the recommendation of an independent review organization (IRO) whenever an adverse determination involves medical questions. In this case, the IRO was asked to opine on whether the treatment the Petitioner received on January 8, 2009, was for a pre-existing condition.

The IRO reviewer in this case is a physician who is board certified in internal medicine, holds an academic appointment, and has been in practice for more than 15 years. The IRO report

said in part:

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 Health Plan defines a "pre-existing condition" as "a disease or physical condition for which medical advice, diagnosis, care or treatment was recommended or received by the Insured Person during the 6 months before the Effective Date of the Insured Person's coverage." The MAXIMUS physician consultant also noted that the member's effective date of coverage was 11/1/08. The MAXIMUS physician consultant indicated that the [Petitioner] was evaluated in the emergency room on 1/3/09 and was told that she was pregnant. The MAXIMUS physician consultant also indicated that the evaluation on 1/8/09 was for generalized pain, including chest pain. The MAXIMUS physician consultant further indicated that the [Petitioner] had generalized tachycardia, which had previously been evaluated by cardiology. The MAXIMUS physician consultant explained that the [Petitioner's] issues related to deep vein thrombosis and possible pulmonary embolus dated back to September 2008. The MAXIMUS physician consultant also explained that the [Petitioner] had multiple emergency room evaluations prior to 1/8/09 for abdominal pain and low back pain. The MAXIMUS physician consultant indicated that there was no documentation showing that the evaluation on 1/8/09 was for an acute problem. The MAXIMUS physician consultant also indicated that there were no specific pregnancy related issues that required treatment on 1/8/09. The MAXIMUS physician consultant explained that the [Petitioner] was treated for deep vein thrombosis, abdominal pain, low back pain and psychiatric issues in September 2008 and October 2008. The MAXIMUS physician consultant also explained that these conditions pre-existed her effective date of coverage on 11/1/08.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the services that the [Petitioner] received on 1/8/09 were for treatment of a pre-existing condition.

The Commissioner is not required 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 that the Petitioner's care on January 8, 2009, was for a pre-existing condition and was therefore excluded from coverage under the terms and conditions of her health plan.

**V  
ORDER**

The Commissioner upholds UniCare Life and Health Insurance Company's final adverse determination of April 27, 2009. UniCare is not required to cover the Petitioner's care at the XXXXX on January 8, 2009.

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