

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. 113568-001

v

Alliance Health and Life
Insurance Company
Respondent

Issued and entered
this _23rd_ day of February 2011
by Ken Ross
Commissioner

ORDER

I
BACKGROUND

On July 13, 2010, 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.* On July 20, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Commissioner notified Alliance Health and Life Insurance Company (Alliance) of the request for external review and requested the information used in making its final adverse determination. The Commissioner received Alliance's response on July 21, 2010.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner receives health benefits through Alliance's "PPO Solo" non-group policy. His policy became effective May 1, 2009.

On September 14, 2009, Dr. XXXXX performed carpal tunnel surgery on Petitioner's right hand. He also received post-surgery physical therapy. Petitioner was initially approved for the surgery and physical therapy. However, Alliance later determined the treatment was for a pre-existing condition and denied coverage.

The Petitioner appealed the denial through Alliance's internal grievance process and received Alliance's final adverse determination letter dated June 16, 2010.

III ISSUE

Did Alliance properly deny the Petitioner coverage for carpal tunnel syndrome surgery and associated physical therapy?

IV ANALYSIS

Petitioner's Argument

In his letter of appeal to Alliance, Petitioner explained why he believes Alliance should cover his carpal tunnel surgery and physical therapy:

I was never advised by my doctor or [Alliance] that this surgery would not be covered. When surgery was scheduled the surgeon's office said [Alliance] had approved surgery. When I went for therapy on my hand, the therapist said [Alliance] approved therapy. Now all of a sudden it is not so.

When I applied on line for [Alliance] Solo the monthly rate was three hundred and some dollars monthly. I answered all questions posed to me, I was then informed my monthly premium would be \$436.00. Not the \$300.00 that was online.

Petitioner maintains his surgery should be covered and his premium returned to the original amount quoted.

Respondent's Argument

In its June 16, 2010, final adverse determination, Alliance denied coverage for the services:

[T]he Alliance Solo PPO Contract you were covered under from May 2009 through March 2010, allowed for the provision of medically necessary covered services provided that a member is "eligible" for such services and satisfies all required referral and authorization guidelines when applicable. Your contract also contained a pre-existing condition clause, in which benefits for any sickness or bodily injury for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period prior to a covered person's effective date of coverage, would not be payable until coverage has been in force for 12 consecutive months with Alliance.

Additionally, the monthly premium for the Alliance Solo PPO Contract you were previously covered under was underwritten based on your specific health history. State Law requires Alliance Solo PPO to obtain health and medical information in order to underwrite each application. This is accomplished through the use of health questions on the application form. In some instances medical records may be requested using the information you supplied on your application.

When you submitted your Solo Application on March 21, 2009, you were specifically asked in question number 24, if you had a muscular skeletal disorder, including carpal tunnel syndrome. You answered "No" to this question. Therefore, when claims were submitted to Alliance for carpal tunnel surgery, three months after your effective date, a medical review occurred in which your medical records were obtained. Your medical records noted documented evidence of treatment for a carpal tunnel diagnosis dating back to November 17, 2008, with your most recent treatment occurring on April 6, 2009.

[A]lthough you were advised that no authorization was required for carpal tunnel surgery and the subsequent occupational therapy you obtained, you were not *eligible* to receive these specific services, due to your preexisting diagnosis for carpal tunnel syndrome, which you failed to disclose at the time you submitted your application to Alliance Solo.

Also, the last page of the application you submitted and signed specifically stated that "there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition" and "any misrepresentation contained herein relied on by the Alliance Health and Life Insurance Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk."

Alliance argues that the requested services do not meet its criteria for coverage and therefore its denial was appropriate.

Commissioner's Review

Alliance's denial of coverage is based on the following provision in the policy:

SECTION 2 – ELIGIBILITY

* * *

2.3 Pre-existing Condition Exclusions

A pre-existing condition is a sickness or bodily injury which would have caused on ordinarily prudent person to seek treatment and for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to a Subscriber's Effective Date of coverage. Generally, this 6-month period ends the day before your coverage becomes effective. Alliance imposes a preexisting condition exclusion ("PCE") which means that if you have a medical condition before enrolling with Alliance, you might have to wait a certain period of time before we will provide coverage for that condition. . . . Benefits for pre-existing conditions are not payable until your coverage has been in force for 12 consecutive months with us. . . .

This provision is permitted in policies of individual coverage by section 3406f(1)(a) of the Michigan Insurance Code, MCL 500.3406f(1)(a). In the Petitioner's case, it excludes coverage during the first twelve (12) months after the effective date of his coverage (May 1, 2009) for any conditions for which medical advice, diagnosis, care, or treatment was recommended or received in the six months before the effective date of his coverage (the period from November 1, 2008, to April 30, 2009).

Petitioner's medical records reveal that Petitioner was diagnosed with carpal tunnel syndrome prior to the effective date of his coverage. On November 17, 2008, Petitioner had an electromyography on his hand which documented he had carpal tunnel syndrome. He also had office visits with his surgeon, Dr. XXXXX, on November 24, 2008, December 15, 2008, January 26, 2009, and April 6, 2009, when he received corticosteroid injections for symptoms related to his diagnosis. Petitioner's surgery took place on August 24, 2009.

Based on this information, Alliance correctly concluded that carpal tunnel syndrome was a preexisting condition for which coverage would be excluded during the first year of Petitioner's coverage.

The Petitioner also stated that the premium he was charged was \$436.00 per month, higher than the \$300.00 premium posted on the Alliance web site when he applied for coverage. The Commissioner notes that \$436.00 was the premium quoted to the Petitioner when he completed his application (see Petitioner's May 2010 letter to Alliance). Thus, the Petitioner was aware of the actual premium before coverage began. It is not clear from the records submitted for this review how the premium was established but because the actual premium was quoted to the Petitioner at the time of the application, there was no misrepresentation of the premium by Alliance.

The Commissioner concludes Alliance's denial is consistent with the terms and conditions of the policy and Michigan law.

V
ORDER

The Commissioner upholds Alliance's June 16, 2010, final adverse determination. Alliance is not required to cover the Petitioner's carpal tunnel syndrome surgery and physical therapy.

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.

Ken Ross
Commissioner