

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. 118546-001

v

Golden Rule Insurance Company
Respondent

Issued and entered
this __1st__ day of April 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

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

The Commissioner notified Golden Rule Insurance Company (Golden Rule) of the external review and requested the information used in making its adverse determination. The Commissioner received Golden Rule's response on January 4, 2011.

The case involves medical issues so the Commissioner assigned it to an independent review organization which provided its recommendation to the Commissioner on January 3, 2011.

II
FACTUAL BACKGROUND

The Petitioner's health care coverage with Golden Rule became effective on March 2, 2010.

On April 19 through April 20, 2010, Petitioner had a laparoscopic recurrent hiatal hernia repair with laparoscopic Nissen fundoplication. Golden Rule denied coverage on the basis that services were not for an emergency, therefore the six-month waiting period applies.

Petitioner appealed the denial through Golden Rule's internal grievance process and received its second level adverse determination dated October 6, 2010.

III ISSUE

Was Golden Rule correct in denying coverage for Petitioner's April 19 through April 20, 2010, medical services?

IV ANALYSIS

Petitioner's Argument

The Petitioner argues that her surgery was treatment for an emergency. In her September 20, 2010, appeal letter to Golden Rule, Petitioner wrote:

In 2008, I underwent Laparoscopic Nissen surgery for acid reflux as well as surgery for a hiatal hernia, which I had lived with for at least 20 years. Although the surgery went well, in late March 2010 my health started to decline rapidly, I was unable to drive, sit up, or do anything that required movement and was to the point that I was bedridden and in severe pain. My stomach specialist, Dr. XXXXX, performed an Upper GI and it was found that something was wrong with the Stomach Wrap. Dr. XXXXX sent me to Dr. XXXXX on May 29, 2010 to discuss my previous laparoscopic Nissen surgery. At that point, I was unable to drive and had to have my neighbor drive me to and from the doctors. When Dr. XXXXX said he did not see anything on the tests, x-rays, or upper GI he sent me to the Emergency Room for more tests. Upon arriving at the Emergency Room I was taken in immediately and given Morphine for the pain, so I was told. The doctor's took me in for a CT scan and were unable to ascertain the cause of the pain and therefore upon discussing the results with Dr. XXXXX, I was sent home with Neurontin for the nerve pain I was receiving from whatever was causing the pain. The pain became worse to the point of severe pain and total incapacity. I contacted Dr. XXXXX on April 12, 2010, who then said that he did see something on the Upper GI and to contact Dr. XXXXX. I then contacted Dr. XXXXX, who again told me he did not see anything. He told me he would get with the radiologist for further investigation in what was causing me the pain. On Wednesday, April 14, 2010 at approximately 3:00 p.m. EST, Dr. XXXXX contacted me to let me know that the stomach wrap had slipped and that they had to do an immediate repair to the Laparoscopic Nissen or my

health would get progressively worse fast causing a life or death situation. He was going out of town for two weeks but said I could not wait that long that he would have to get me in as soon as possible. He then called me back at approximately 3:15 p.m. and told me I was scheduled for surgery on Monday, April 19, 2010 at 11:30 a.m.

Petitioner argues that her care on the dates in question should be covered because the care was urgently needed. She says her claim should be covered because, at the time, she was in a lot of pain and this was an emergency.

Respondent's Argument

In its October 6, 2010, final adverse determination, Golden Rule wrote:

[T]he claims in question were denied due to a six-month waiting period provision included in your Certificate of Insurance that applies to certain conditions, including hernia. As indicated in your certificate, this exclusion will not apply if the treatment is provided on an emergency basis.

Golden Rule cited the following provision in the certificate:

WAITING PERIODS: There is a 14-day waiting period for all *illnesses*.

There is a six-month waiting period for certain conditions.

Expenses incurred by a *covered person* for the treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia or any disorders of the reproductive organs will not be covered during the *covered person's* first six months of coverage under the *policy*. This exclusion will not apply if the treatment is provided on an *emergency* basis.

After the six-month period, the condition will be subject to all the terms of the *policy*, just like any other condition.

Golden Rule states that the medical services Petitioner received were for diagnosis and treatment of a hernia. For that reason, and because the treatment occurred during the first six months after the effective date of the policy, the services were excluded from coverage. Golden Rule believes that its denial of coverage was appropriate.

Commissioner's Analysis

The first issue to be resolved is whether the medical care was so urgent as to constitute a medical emergency, which is defined in the policy as "an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours."

The question of whether Petitioner's hernia repair was emergency treatment was presented 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). The review was conducted by a physician in active practice who is certified by the American Board of Surgery and who is a Fellow of the American College of Surgeons.

The IRO reviewer's report includes the following analysis:

Based on the definition of emergency, the laparoscopic Nissen re-fundoplication and repair of recurrent hiatal hernia surgery is not considered an emergency procedure. The [Petitioner's] medical therapy was not maximized prior to pursuing surgery.

According to the ER note, this condition had been a problem for the [Petitioner] since January of 2010 (4 months prior to her surgery). For patients who have recurrent dyspepsia symptoms, the recommendation is to maximize medical therapy with surgery indicated for therapeutic failures. The ER notes indicate she was on single does of omeprazole (20 milligram [mg]) which can be increased up to 40 mg twice a day for symptomatic treatment. She did not have weight loss, anemia, ulceration seen on upper GI study, or pulmonary compromise from her recurrent hiatal hernia – these would be indicators for early reoperation rather than maximizing medical management. The operative notes do not support a high risk for gastric torsion or volvulus since all her short gastric vessels were taken down during her first procedure and there was no evidence of bowel compromise or anatomy described in the operative report to support that.

The IRO reviewer concluded that Petitioner's hernia repair was not provided on an emergency basis.

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. Therefore, the Commissioner accepts the findings of the IRO that Petitioner's medical care did not involve a medical emergency.

The remaining question is whether the treatment, though not an emergency, should be covered under the terms of the policy. Golden Rule has included in its policies a six-month waiting period for certain medical conditions, including hernia, before coverage for those conditions becomes effective. Such restrictions are not prohibited under Michigan law. The Commissioner can find no basis under the terms of the policy to overturn Golden Rule's processing of the claims in this case. The claims denials were consistent with the specific coverage limitations quoted above.

The Commissioner therefore finds that Golden Rule's denial of coverage was correct and permissible under the certificate of coverage.

**V
ORDER**

The Commissioner upholds Golden Rule's October 6, 2010, final adverse determination. Golden Rule is not required to provide coverage for Petitioner's April 2010 treatment.

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