

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 119174-001

v

Time Insurance Company
Respondent

Issued and entered
this ____ day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On January 20, 2011 XXXXX, authorized representative of his father 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.* On January 27, 2011 the case was accepted for review.

Because the case involves medical issues it was assigned to an independent medical review organization, which completed its review and sent its recommendation to the Commissioner on February 17, 2011.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in a short term medical policy issued by Time Insurance Company. The policy became effective on December 22, 2009 and terminated March 27, 2010.

Between February 18 and March 24, 2010, Petitioner received a double heart bypass and related treatment. Time denied coverage for this care asserting that the care was treatment for a pre-existing condition. The cost of the surgery and related treatment was \$64,767.15.

The Petitioner appealed Time's decision through its internal grievance process. Time maintained its position and issued its final adverse determination dated November 24, 2010.

III. ISSUE

Did Time properly deny coverage for Petitioner's treatment?

IV. ANALYSIS

Respondent's Argument

In its November 24, 2010 final adverse determination Time denied coverage stating in part:

The Pre-Existing Condition Limitation section of the contract states, "We will not pay benefits during Your Benefit Period for charges incurred due to a Pre-Existing Condition.

* * *

Our Health Management department reviewed the medical records from XXXXX and XXXXX Physicians. . . . Based on the original medical records, the coronary artery disease is a pre-existing condition, and all related charges and complications are not covered. . . .

Based on a review of the records, Time concluded that the Petitioner's heart bypass and related care was treatment of a pre-existing condition and not a covered benefit. Time contends its determination was in compliance with the terms of the certificate.

Petitioner's Argument

In his request for external review, the Petitioner's representative wrote:

The original basis of [Time's] claim that [Petitioner] had a pre-existing condition arose out of his February, 2009 annual physical . . . with Dr. XXXXX. The physical showed that [Petitioner] was otherwise healthy but Dr. XXXXX in her closing patient status stated, "good, chest pain is somewhat concerning re that it is so exertional would very much like him to have a stress test." In the examination report, Dr. XXXXX suggested three separate tests: "SCREENING MALIGNANT NEOPLASM : PROSTATE, LIPID PANEL and REGULAR TREADMILL STRESS TEST."

* * *

At the time of his annual physical exam with Dr. XXXXX, [Petitioner] had nothing more than a tightness in his left shoulder muscle experienced when working in cold weather. . . . Nothing in the record indicates that [Petitioner] received more than a recommendation that he take a stress test - in fact, this was one test among several

which are age appropriate for a sixty year old male construction worker. He received no medical advice for a heart condition, he was not diagnosed with a heart condition, he had no treatment for a heart condition and he neither received nor was recommended care for a heart condition. A mere recommendation to take a stress test does not constitute a diagnosis since no actual analysis occurred. [Time] confuses the term “diagnosis” with “symptom” when it labels “unspecified chest pain “as a diagnosis. . . .

The most that can be inferred from the 2009 physical examination record is that [Petitioner] was having “unspecified chest pain” when working in cold weather. This does not meet even the most basic definition of having a pre-existing condition. . . .

The Petitioner believes that his heart bypass surgery and related care provided from February 18 through March 24, 2010 is not treatment of a pre-existing condition and Time should provide coverage for all the care in question.

Commissioner’s Review

The policy (p. 6) defines pre-existing conditions as:

A medical condition due to Sickness or Injury:

1. For which the Insured received medical advice, diagnosis or care or for which treatment was recommended or received from a provider within the 5-year period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the Effective Date of coverage.

The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
- b. The signs or symptoms should have caused an ordinary prudent person to seek diagnosis or treatment. . . .

The question of whether the medical services Petitioner received from February 18 through March 24, 2010 were treatment of a pre-existing condition was presented to an independent review organization (IRO) for review. The IRO reviewer assigned to this case is a physician in active practice who is board certified in internal medicine and is an associate clinical professor at a university-based school of medicine. The reviewer is a fellow of the American College of Physicians and a member of the American Society of Internal Medicine. After reviewing the Petitioner’s medical records, the reviewer reached the following conclusion:

The [Petitioner] was seen for symptoms that were suggestive of coronary artery

disease in the year prior to the effective date of December 22, 2009. According to plan language, the [Petitioner's] coronary artery disease is thus a pre-existing condition. The services provided from February 18, 2010 through March 24, 2010 were treatment for a pre-existing condition.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, a recommendation from the IRO 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 the IRO's recommendation that the Petitioner's care was treatment of a pre-existing condition should be rejected in the present case.

The Commissioner finds that Time correctly applied the terms of their certificate in denying coverage for the care Petitioner received from February 18 through March 24, 2010.

V. ORDER

The Commissioner upholds Time Insurance Company's final adverse determination. Time is not required to provide coverage for the heart bypass surgery and related care the Petitioner received from February 18 through March 24, 2010 since it was treatment of a pre-existing condition which is excluded under the policy.

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.

R. Kevin Clinton
Commissioner