

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

v

File No. 116891-001

Celtic Insurance Company
Respondent

Issued and entered
this 11th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. Procedural Background

On November 16, 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the information that was submitted by both parties and accepted the request on November 23, 2010.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization, which completed its review and sent its recommendation to the Commissioner on December 13, 2010.

II. Factual Background

The Petitioner's health care benefits are defined in Celtic's *Major Medical Expense Policy*. On August 1, 2009, Petitioner's health care coverage with Celtic became effective. On January 12, 2010, he had surgery on his knee. Celtic denied coverage for this surgery as treatment of a pre-existing condition. The Petitioner appealed Celtic's denial through its internal grievance process. Celtic maintained its position and issued a final adverse determination September 21, 2010.

III. Issue

Did Celtic properly deny coverage for the Petitioner's January 12, 2010, surgery as treatment of a pre-existing condition?

IV. Analysis

Respondent's Argument

Celtic based its decision on the following provision in its policy (p. 34):

Pre-existing Conditions Limitation

A pre-existing condition is a sickness or bodily injury for which an insured person received a diagnosis, medical advice, consultation or treatment from a physician during the 6 months prior to the effective date of coverage, or which, in the opinion of a physician, caused symptoms during the 6 months prior to the effective date that were obvious enough to cause an ordinarily prudent person to seek diagnosis, medical care or treatment.

Benefits are paid for an insured person's pre-existing condition once coverage is in force for 12 continuous months after the effective date, unless specifically excluded from coverage under this policy.

Any treatment or service for an excluded pre-existing condition, including any complications or conditions resulting from treatment of a pre-existing condition are not eligible expenses.

In its final adverse determination, Celtic cited Petitioner's medical records which described a history of knee pain and treatment at the XXXXX in early 2009. Since the Petitioner's surgery of January 12, 2010, was for treatment of these conditions and took place within 12 months of the effective date of his policy, Celtic concluded that the surgery was treatment of a pre-existing condition and, for that reason, was not eligible for coverage under the policy language.

Petitioner's Argument

The Petitioner argues that his medical problems were not related to a pre-existing condition as Celtic claims. Petitioner indicates that prior to his surgery the diagnosis was left knee pain with osteoarthritis and patellofemoral discomfort. The diagnosis information used to determine this condition did indicate chondrocalcinosis of the meniscus which the Petitioner understands to be an inflammation of the knee joint.

Celtic denied coverage for the surgery indicating the February 25, 2009, x-ray revealed a significant lateral compartment and patellofemoral compartment degenerative disease of the left knee. However, the Petitioner believes there was no mention of "significant" in the medical

records of February 25, 2009. He indicates the diagnosis was unknown as of the February 25, 2009 visit. He asserts that the December 10, 2010, MRI indicated a “thinning and abnormal signal at the lateral meniscus, probable degenerative horizontal tear”. He states there is no evidence this probable tear did not occur after his August 1, 2009, effective date.

Petitioner argues that since it cannot be determined that the tear happened prior to the start of his policy, it cannot be determined that his surgery was for treatment of a pre-existing condition. Therefore, he believes this care is a covered benefit and Celtic is required to pay for it.

Commissioner’s Review

The Commissioner must determine whether the surgery and related services that Petitioner received on January 12, 2010, constituted treatment of a pre-existing condition. The question was presented to an independent review organization (IRO) for analysis. The analysis was performed by physician who is board certified in orthopedic surgery and has been in active practice for more than 18 years. The reviewer’s report included the following analysis and conclusions:

. . . On 1/12/10, the member underwent surgery to repair a torn medial meniscus and torn lateral meniscus, chondroplasty of the patellofemoral joint, limited lateral retinacular release and anterior cruciate ligament repair of the left knee. At issue in this appeal is whether this surgery and related services were for treatment of a pre-existing condition.

. . . [M]edical records document that the member had knee pain in February 2009. . . . [A]n x-ray of the member’s left knee performed on 2/25/09 revealed significant lateral compartment and patellofemoral compartment degenerative disease. . . . [T]he medical records provided for review clearly show that the member had a degenerative knee condition prior to his enrollment in the Health Plan. . . . [T]he member’s meniscus was degenerative for a long time prior to his surgery on 1/12/10.

Pursuant to the information set forth above and available documentation, the [reviewer] determined that the surgery that the member underwent on 1/12/10 and related services were for treatment of 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 should be rejected in the present case.

The Commissioner finds that Celtic correctly applied the terms of the policy in denying coverage for the Petitioner's January 12, 2010, surgery and related medical care as treatment of a pre-existing condition.

V. Order

The Commissioner upholds Celtic Insurance Company's September 21, 2010, final adverse determination. Celtic is not required to provide coverage for the January 12, 2010, surgery and related medical care.

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