

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. 119509-001

v

John Alden Life Insurance Company
Respondent

Issued and entered
this __4th__ day of August 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On February 9, 2011, 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 February 16, 2011, the case was accepted for review.

The issue in this external review can be decided by analysis of Petitioner's health benefit plan certificate of coverage (the certificate) which is underwritten by John Alden Life Insurance Company. The Commissioner reviews contractual issues pursuant to MCL 550.1911 (7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's insurance coverage became effective April 15, 2010. On September 27, 2010, Petitioner received medical imaging services (mammograms and an ultrasound) at XXXXX Hospital. The charges totaled \$593.50. John Alden denied coverage for this care asserting that the care was treatment of a pre-existing medical condition. The Petitioner appealed John Alden's decision through its internal grievance process. John Alden maintained its position and issued its final adverse determination January 31, 2011.

III. ISSUE

Did John Alden properly deny coverage for Petitioner's September 27, 2010 medical imaging services as a pre-existing condition under the terms of the certificate?

IV. ANALYSIS

Respondent's Argument

John Alden's final adverse determination states:

Medical records obtained from Dr. XXXXX were reviewed by our Health Management Services Department. It has been determined that the condition treated is related to a pre-existing condition. We are unable to consider any charges related to the condition billed for these services until the pre-existing condition period is expired on April 15, 2011. The rationale for this determination is as follows:

'The patient's appeal letter asserts that September 23, 2010 was the first time she was found to have a mass on the left breast. This is not consistent with the contemporaneous medical records obtained from Dr. XXXXX's office. Those records show that this individual sought care from Dr. XXXXX's on December 4, 2009 for a left breast cyst. An ultrasound on the left breast was scheduled. Because this visit did not correlate with the appeal letter, I called Dr. XXXXX's office and spoke to XXXXX. She confirmed the accuracy of the December 4, 2009 visit date and that the ultrasound was set up for December 15, 2009. She also noted that the record did not contain an ultrasound report and did not know if the scheduled ultrasound was completed. I also discussed with her that the exam referenced a right breast cyst. XXXXX confirmed that the complaint was for the left side, the assessment was for the left side and the order was for a left ultrasound. She stated she would ask Dr. XXXXX to correct the examination note. If that scheduled ultrasound was completed and normal, submission of such a report would allow this determination to be reconsidered. Otherwise the determination of a Pre-existing Condition is upheld.'¹

Petitioner's Argument

The Petitioner denies that the mammogram was treatment for a pre-existing condition. She states that the two "conditions" to which John Alden refers involve different breasts and, in

¹ The "rationale" appears to be a quotation taken from a separate document although that document is not identified in any material the Respondent submitted to the Commissioner.

any case, are not for the same – or even related – conditions. Petitioner states that on December 4, 2009, prior to having coverage with John Alden, she saw her doctor because of a cyst on her right breast that turned into an abscess. While her doctor recommended a mammogram, she could not afford a mammogram. The cyst eventually cleared up without further treatment. She knows that this was on her right breast because she still has a scar from the abscess.

Petitioner states that her John Alden coverage began on April 15, 2010. Five months later, on September 23, 2010, she went to her doctor for a routine pap smear. The doctor felt a “soft movable mass” in Petitioner’s left breast and ordered a mammogram. The Petitioner states that she had never been seen or diagnosed with anything on her left breast prior to that time. The Petitioner states she has documented information from her doctor’s 2009 examination that shows that the cyst was on her right breast.

Petitioner argues that the September 27, 2010, mammogram was not treatment for a pre-existing condition and John Alden should be required to pay for it.

Commissioner’s Review

This appeal requires the resolution of two issues: Whether the Petitioner’s 2009 examination involved Petitioner right or left breast, and whether the medical care provided to Petitioner in September 2010 constituted treatment of a pre-existing condition.

Regarding the question of which breast was the subject of Petitioner’s 2009 examination, the Commissioner notes that the Petitioner has submitted a record of that examination which indicates she had a cyst on her right breast. Respondent has submitted a different version of the same form which includes four separate references to a breast abnormality. Three of those references are to the left breast, one to the right breast. The Commissioner notes that neither party has submitted any documentation from the physician who conducted the 2009 examination.

Respondent has submitted a document indicating that someone at John Alden contacted the physician and was given assurances from “XXXXX” that she would speak to the doctor and correct the examination notes to show that the Petitioner’s complaint was “for the left side.” The record is devoid of any indication of who “XXXXX” is, how she knew months later which breast was examined, or whether the doctor actually authorized any change in the record. Fortunately, it is not necessary to resolve the questions in order to resolve this appeal.

The following provisions appear in the Petitioner’s policy:

Pre Existing Condition

A condition, whether physical or mental, regardless of the cause of the condition,

for which medical advice, diagnosis, care or treatment was recommended or received with the 6-month period ending on the Enrollment Date. The period of any such Pre-Existing Condition exclusion is reduced by the aggregate of the periods of Creditable Coverage applicable to the participant or beneficiary as of the Enrollment Date. The Pre-Existing Condition definition will not apply to pregnancy, newly born and adopted children. (Policy, p. 28)

We will not pay benefits for any of the following:

* * *

3. Charges that are related to or a complication of a Pre-Existing Condition. (Policy, p. 63)

Pre-Existing Conditions Limitation

We will not pay benefits under this plan for an otherwise Covered Charge that is related to a Pre-Existing Condition for 12 months after the Employee's Enrollment Date. After this period, benefits will be available for a Pre-Existing Condition provided that the Covered Charges are Incurred while this coverage is in force. (Policy, p. 71)

Applying these provisions in order to deny coverage to an insured, it is necessary for the insurer to establish that a medical condition exists at the time of the disputed medical care and that this condition existed prior to the beginning of the insured's coverage. Without a present medical condition, there can be no "pre-existing condition" to be excluded.

Based on the uncontested portion of the information submitted by both parties, it is clear that Petitioner's 2009 medical problem was for a cyst that resolved itself without further treatment. Petitioner's 2010 medical problem was her doctor's detection of a mass inside her breast. This mass was later found to be no mass at all. The radiologist's report found that:

The breast tissue is heterogeneously dense. This may lower the sensitivity of mammography. There is no discrete abnormality including area of concern of palpable at 4 o'clock left breast upper outer quadrant.

Respondent has failed to establish that a medical condition existing in 2010 was related to any medical condition which existed in 2009. The Commissioner therefore finds that the Petitioner's September 27, 2010, medical care was not treatment of a pre-existing condition and is, therefore, a covered benefit under the Petitioner's policy.

V. ORDER

The Commissioner reverses Respondent's final adverse determination of January 31, 2011. John Alden is ordered to provide coverage for the medical imaging services (mammograms and ultrasound) the Petitioner received at XXXXX Hospital on September 27, 2010. Coverage shall be provided within 60 days of the date of this Order. Respondent shall provide the Commissioner proof of coverage within seven days after coverage is provided.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

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