

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████
Petitioner

v

File No. 147301-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 4th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 13, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On April 20, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits under an individual plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. The Director received BCBSM's response on April 29, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. See MCL 550.1911(7).

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Keep Fit and Member Edge Individual Market Certificate*. Her coverage became effective December 1, 2014. The certificate includes a 180-day waiting period for pre-existing conditions.

On December 11, 2013, the Petitioner had surgery at ██████████ to remove an ovarian mass. She was hospitalized from December 10 to December 12, 2013. The

amount charged for this care was \$14,296.74. BCBSM denied coverage, ruling that the surgery was treatment of a pre-existing condition.

The Petitioner appealed BCBSM's claim denial through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 26, 2015, upholding its payment denial. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's surgery and related services?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination, BCBSM's representative explained to the Petitioner:

On the referenced dates of service you were covered under the *Keep Fit and Member Edge Individual Market Certificate*. On page 1.6 of your certificate, under **Section 1: Information About Your Contract, Contract Dates, When Your Benefits Began** it states:

Services for pre-existing conditions are not covered during the first 180 days of your coverage, beginning on the effective date. Unless noted otherwise, all covered services and benefits are subject to a 180-day waiting period for pre-existing conditions. The 180-day waiting period begins on the first day of your coverage becomes effective, not the date your application was submitted.

A board-certified M.D. in Family Practice reviewed your claim, your appeal, and your health care plan benefits for [BCBSM]. The effective date of your coverage was December 1, 2013 and the look back period for pre-existing conditions was June 3, 2013 to November 30, 2013. The notes submitted by [REDACTED] M.D., dated August 14, 2013, stated a firm mass was found in your abdomen. In August 2013, an abdominal ultrasound was performed which confirmed a pelvic mass. Also, in August 2013 you were referred to GYN oncologist [REDACTED] M.D., who referred you to [REDACTED], a reproductive endocrinologist. On November 4, 2013, you had a consultation with [REDACTED] who confirmed a 13 cm right ovarian mass and recommended the surgery that was performed on December 11, 2013. Based on the documentation submitted, you received medical advice, you were diagnosed and treatment was recommended for diagnosis codes 220 (Benign neoplasm of ovary)

and 236.2 (Ovary-Neoplasm of uncertain behavior of genitourinary organs) during the look back period. Therefore, a positive pre-existing condition was found.

Petitioner's Argument

On the request for external review form the Petitioner wrote:

I'm writing this rebuttal that my surgery was not pre-existing. When I saw [REDACTED] (thyroid doctor) she found the tumor. First time I've ever had issues in my pelvic area. Pre-existing is a condition that I would have been treated for a long time. The only thing I was treated for was thyroid hypo condition. When I had my GYN exam in 2011, I never had any issues.

I don't feel I should pay for this surgery – I had insurance for surgery.

Director's Review

The *Keep Fit and Member Edge* certificate states on page 1.6:

Most benefits are available on the effective date of your contract. However, services for pre-existing conditions are not covered during the first 180 days of your coverage, beginning on the effective date....

Page 8.25 of the certificate defines a pre-existing condition as:

A condition for which medical advice, diagnosis, care or treatment was recommended or received within 180-day period ending on the enrollment date.

BCBSM listed in its final adverse determination the medical evaluation and treatment recommendations the Petitioner received in the six months that preceded the effective date of her coverage:

- On August 14, 2013 [REDACTED] doctor found a hard mass in the Petitioner's abdomen.
- In August 2013 an abdominal ultrasound was performed which confirmed a pelvic mass.
- On November 4, 2013, [REDACTED] confirmed a 13 cm right ovarian mass and recommended the surgery that was performed on December 11, 2013.

This information establishes that, within the 180 days prior to her effective date of

coverage, the Petitioner received diagnosis and advice for her ovarian mass. Therefore, the medical care at issue in this appeal constituted the treatment of a pre-existing medical condition as that term is defined in the *Keep Fit and Member Edge* certificate. Therefore, that treatment is excluded from coverage.

The Director finds that BCBSM's denial of coverage was consistent with the terms of the certificate.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 26, 2015.

This is a final decision of an administrative agency. 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 Michigan county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1). A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director