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. 117689-001**

v

American Community Mutual Insurance Company
Respondent
_____/

Issued and entered
this 2nd day of May 2011
by R. Kevin Clinton
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 21, 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 case was accepted for review on October 28, 2010. 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 November 10, 2010.

II
FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in an American Community limited medical expense policy which became effective on January 1, 2010. Prior to January 1, 2010, the Petitioner had individual coverage with Aetna Health Insurance Company.

At issue in this review is coverage for medical treatment on several dates in February,

March, and June 2010 when Petitioner was treated in XXXXX for polyps and abdominal pain at XXXXX Patient Care, a practice group specializing in digestive disease. American Community provided coverage for some services but denied others asserting that the care was treatment of a pre-existing condition.

The Petitioner appealed American Community's decision through its internal grievance process. American Community maintained its position and issued it final adverse determination dated October 6, 2010.

III
ISSUE

Did American Community properly deny coverage for Petitioner's treatment?

IV
ANALYSIS

Petitioner's Argument

In his request for external review, the Petitioner wrote:

> American Community continues to insist that my problems were a pre-existing condition. My doctor however has provided medical proof that my condition, where the polyp was discovered, is not a pre-existing condition.

In a letter to American Community dated August 13, 2010, XXXXX Patient Care staff summarized Petitioner's treatment:

> [Petitioner] has seen us in 2005 for a colonoscopy and EGD. Everything came out pretty benign and we did not see him again until his primary [physician] asked for a consult. We saw him in consultation on 3/17/10. We performed another EGD on 3/19/10. At the time of this procedure, Dr. XXXXX noted gastric polyps and removed them. They were not mentioned on the report from 2005. Dr. XXXXX recommended that we perform another EGD in 3 to 6 months to verify that the gastric polyps [were] removed as it did show adenomatous changes. The follow up EGD was performed on 6/28/10. Dr. XXXXX suggested that the patient have another EGD in two years.

For these reasons Petitioner believes American Community should provide coverage for all the dates in question.

Respondent's Argument

In its October 6, 2010 final adverse determination American Community denied coverage stating in part:

> Your policy with American Community, which was effective January 1, 2010, excludes coverage of pre-existing conditions. . . . Your medical records of July 3, July 15 and December 9, 2009 document that you were taking Omeprazole daily to treat heartburn. You consulted Dr. XXXXX on December 9, 2009 regarding a month-long history of pain under your left ribcage. The doctor referred you for a CT scan of your abdomen and pelvis due to your left-sided abdominal pain. When you returned to his office on February 17, 2010 due to left upper quadrant abdominal pain since October, he again recommended a CT scan and referred you to a gastroenterologist.
>
> Because you were treated for left-sided abdominal pain and heartburn within six months before your policy with American Community became effective on January 1, 2010, these conditions were determined to be pre-existing. After careful review and consideration of all the pertinent information, the determination that abdominal pain and gastroesophageal reflux disease are pre-existing conditions as defined by the language of your policy has been upheld.

American Community cited the following provisions of the certificate to support its decision:

> **Medical Definitions**
>
> Pre-existing Condition means a condition for which medical advice, diagnosis, care or Treatment was recommended or received within 6 months before the Effective Date. An illness or disease which appeared prior to the Effective Date of the Family Member's coverage, was fully disclosed on the application and was not excluded from coverage by a rider is not a Pre-existing Condition.
>
> **General Exclusions**
>
> - Pre-existing Conditions. We do not pay for any expenses incurred due to any Pre-existing Condition cutting the 12 months immediately following the Effective Date.

American Community contends its determination was in compliance with the terms of the certificate.

Commissioner's Review

The question of whether the medical services Petitioner received from February through June 2010 were treatment of a pre-existing condition was presented to an independent medical

organization (IRO) for review. The IRO reviewer assigned to this case is a physician who is board certified in gastroenterology and has been in active practice for more than 15 years. The reviewer's report included the following analysis and conclusions:

> [T]he member saw his primary care physician on 2/17/10 due to left upper quadrant abdominal pain and was referred for a CT scan and to his gastroenterologist. . . . [T]he member was seen for a consultation on 3/17/10 and underwent an EGD on 3/19/10, during which a gastric polyp was removed. . . . [A] follow-up EGD was performed on 6/28/10 to make sure that no additional polyps were present. . . . [P]rior to the EGD, the member underwent a CT scan on 2/19/10, which showed thickening of the gastric fundus and body. . . . [T]he services in February 2010 and March 2010 were for a pre-existing condition. . .[T]he member has a history of years of ill-defined dyspepsia and heartburn and has been taking a proton pump inhibitor. . . . [T]he services that the member received on 3/17/10 and 3/19/10 were for evaluation of left upper quadrant pain and gastroesophageal reflux symptoms. . . . [T]he EGD performed on 6/28/2010 was not for treatment of a pre-existing condition because this testing was performed in follow-up to the gastric polyps, which were found on 3/19/10.
>
> The services that the member received in February 2010 and March 2010 were for diagnosis and treatment of a pre-existing condition, but the services he received on 6/28/10 were not for diagnosis and 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 American Community correctly applied the terms of their certificate in denying coverage for the care Petitioner received in February and March 2010. The Commissioner also finds that American Community did not correctly apply the terms of their certificate in denying coverage for the care Petitioner received on June 28, 2010.

V

ORDER

The Commissioner reverses in part American Community Mutual Insurance Company's final adverse determination. American Community is not required to provide coverage for the February and March 2010 dates of service but shall provide coverage for care Petitioner received on June 28, 2010. American Community shall provide coverage within 60 days of the date of the Order and shall, within seven days of providing coverage, provide the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding the 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 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.

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R. Kevin Clinton
Commissioner