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. 123046-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _6th____ day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 24, 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, MCL 550.1901 *et seq*. The Commissioner reviewed the material submitted and accepted the request on September 1, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information it used in making its adverse determination. The Commissioner received BCBSM's response on September 13, 2011.

Because it involved medical issues, the Commissioner assigned the case to an independent review organization which provided its analysis and recommendation on September 15, 2011.

II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in BCBSM's *Flexible Blue II Individual Market Certificate* (the certificate). His coverage became effective on February 15, 2010.

From July 17 to July 25, 2010, the Petitioner was a patient at XXXXX Hospital where he was treated for Crohn's disease. His attending physician was Dr. XXXXXX. The amount

charged for this care was $35,412.44. BCBSM denied coverage ruling that the care was for treatment of a pre-existing condition.

The Petitioner appealed BCBSM's denial of coverage for medical care provided by XXXXX Hospital and Dr. XXXXX After a managerial-level conference on July 29, 2011, BCBSM did not change its decision and issued a final adverse determination on August 9, 2011.

III. ISSUE

Is BCBSM required to provide coverage for the Petitioner's medical care received July 17-29, 2010?

IV. ANALYSIS

BCBSM's Argument

In the final adverse determination sent to Petitioner, BCBSM's analyst wrote:

> Your coverage with us began on February 15, 2010 and the waiting period was exhausted on August 13, 2010. Any services received during the "look back period" (September 2009 to February 2010) are reviewed to determine if the condition is pre-existing. As you know, I was able to locate the completed Medical Treatment History Request form and the medical records that were previously submitted.
>
> Our medical consultants reviewed that documentation and determined that your condition was pre-existing. Dr. XXXXX's office notes of January 14 and January 29, 2010 reflected that you were seen for gastrointestinal issues and bleeding. You were advised to have a colonoscopy if you were not any better. It appears that after two months, the problems ceased until your admission. Because the visits of January 14 and 29 were related to the same issue, even through you were not actually diagnosed, it is considered pre-existing. As a result no payment can be approved for any of the claims.

Petitioner's Argument

In his request for external review, the Petitioner wrote:

> . . . I disagree with the decision to declare my condition as pre-existing because my condition was not diagnosed before my BCBS coverage became effective on February 15, 2010. I had medical visits with my personal care physician XXXXX, D.O. on January 14 and 29 of 2010 concerning minor symptoms. After the physician visits in January my symptoms improved, and in fact, they completely disappeared. Months passed, and in June 2010 I was hospitalized with severe

> symptoms. Between the dates of June 27 to June 30, 2010 I was diagnosed with Crohn's disease through a colonoscopy and biopsy at XXXXX Hospital in XXXXX MI. This diagnosis was well after my BCBSM coverage became effective on February 15, 2010.

Commissioner's Review

The Petitioner's *Flexible Blue* certificate of coverage excludes coverage for pre-existing conditions during the first 180 days following the effective date of coverage. The certificate defines a pre-existing condition as a condition "for which medical advice, diagnosis, care or treatment was recommended or received within the 180-day period ending on the enrollment date."

To answer the question of whether the Petitioner's July 2010 care was for treatment of a pre-existing condition, the Commissioner presented that question to an independent medical review organization (IRO) for review. The IRO was provided with medical records and other documents submitted by the Petitioner and BCBSM.

The IRO's reviewer for this case is a physician in active practice who is certified by the American Board of Internal Medicine with a subspecialty in gastroenterology. The IRO reviewer's report includes the analysis and conclusion below. (A copy of the complete report is being provided to the parties with this Order.)

> The plan definition of pre-existing condition (PEC) is, a condition for which medical advice, diagnosis, care or treatment was recommended within the 180 day period ending on the enrollment date. Enrollment date in this case was February 1, 2010. Certificate Effective Date was February 15, 2010. The "Look-back period" is August 2009 to February 2010. Since the enrollee was having persistent bloody stools for over a month, prior to February 1, 2010, was treated with 2 courses of antibiotics and did not improve, had negative stool cultures and no evidence of a gastroenteritis, it appears that a flare of Crohn's disease was occurring throughout January of 2010. The enrollee was advised to have a colonoscopy, but apparently due to lack of health insurance, a colonoscopy was not performed at that time.
>
> Eventually the enrollee was hospitalized with a flare of IBD when the diagnosis was confirmed. On June 28, 2010, the enrollee complained of blood in the stools and was admitted June 27, 2010 through June 30, 2010. Stool cultures were negative. Computed tomography (CT) scan showed descending colitis. Colonoscopy showed cobblestone appearance of the colonic mucosa consistent with Crohn's colitis. The enrollee improved with Asacol and Prednisone.

> The enrollee was then admitted again to the hospital on July 17, 2010 with discharge on July 25, 2010. Hospital course described a diagnosis of Crohn's disease. The enrollee was noncompliant with Asacol and he did not improve in symptoms. Hemoglobin was 8.7. He was placed on Prednisone, Sulfasalazine and Lortab for pain and improved.
>
> The enrollee again went to the hospital on July 29, 2010. CT scan showed mild pancolitis, no appendicitis.
>
> Eventually on December 23, 2010, a repeat CT scan showed no evidence of colitis.
>
> The literature shows that with respect to the clinical manifestations of Crohn's disease, patients can have symptoms for many years prior to diagnosis. Fatigue, prolonged diarrhea with abdominal pain, weight loss, and fever, with or without gross bleeding, are the hallmarks of Crohn's disease. This supports that although a diagnosis was made in June of 2010, the existence of Crohn's disease accounted for the January of 2010 presentation. Hence a PEC existed. . . .
>
> **Recommendation:**
>
> It is the recommendation of this reviewer that the denial issued by Blue Cross Blue Shield for services rendered July 17, 2010 through July 29, 2010 be upheld.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation 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 reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner accepts the recommendation of the IRO and finds that the Petitioner's care for the period of July 17 through July 29, 2010, was for treatment of a pre-existing condition and, therefore, not a covered benefit under the certificate.

V. ORDER

The Commissioner upholds the final adverse determination of Blue Cross Blue Shield of Michigan dated August 9, 2011. BCBSM is not required to cover the Petitioner's care provided from July 17 to 29, 2010.

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 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