

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. 154560-001

Health Alliance Plan of Michigan
Respondent

Issued and entered
This 22nd day of August 2016
By Randall S. Gregg
Special Deputy Director

ORDER

I. BACKGROUND

On July 13, 2016, ██████████ (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.*

The Petitioner receives health care benefits from Health Alliance Plan of Michigan (HAP), a health maintenance organization. The Petitioner's benefits are defined in HAP's *Subscriber Contract*.

The Director notified HAP of the external review request and asked for the information used to make its final adverse determination. HAP provided its response on July 18, 2016. After a preliminary review of the information submitted, the Director accepted the request on July 20, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On November 16, 2014, the Petitioner was in New Hampshire and began to have a problem with his right eye. He went to ██████████ Urgent Care Center in ██████████, New Hampshire. The urgent care doctor suspected he had a detached retina, a condition

which could not be treated there. The Petitioner was instructed to go to the Lawrence (Massachusetts) General Hospital emergency department. The urgent care doctor contacted Lawrence General and the on-call doctor [REDACTED], happened to be a physician with New England Eye and Facial Specialists [REDACTED] stated that the Petitioner required evaluation with equipment Lawrence General did not have and suggested that the Petitioner should go to the doctor's Andover, Massachusetts office where the required evaluation could be conducted.

The evaluation was performed at the Andover office on November 16, 2014. Dr. [REDACTED] charge was \$390.00. Dr. [REDACTED] filed a claim with HAP. On November 19, 2014 the Petitioner had surgery to repair his retina at Lawrence General Hospital. HAP provided coverage for the November 19 surgery, but denied coverage for Dr. [REDACTED] November 16 services.

HAP informed Dr. [REDACTED] of its decision to deny coverage but did not inform the Petitioner of its decision. The Petitioner learned of the coverage denial in 2016. At that time, the Petitioner filed his own claim with HAP for the November 16, 2014 medical care. HAP, in a letter to the Petitioner dated July 1, 2016, rejected the Petitioner's appeal as untimely.

III. ISSUE

At issue in this appeal is HAP's denial of coverage for Dr. [REDACTED] November 16, 2014 medical care.

IV. ANALYSIS

Respondent's Argument

HAP has cited two reasons for its denial of coverage:

- The Petitioner's appeal was filed after the expiration of the 180 day period to file an appeal.
- Dr. [REDACTED] had filed a claim for an office visit on November 16, 2014. Dr. [REDACTED] is a nonparticipating provider and treatment from a nonparticipating provider require prior authorization from HAP.

In an August 16, 2016 letter to the Department of Insurance and Financial Services (DIFS), HAP wrote:

According to our review, on June 29, 2015, HAP received the claim

from Dr. [REDACTED] for services that [Petitioner] received on November 16, 2014 totaling \$390. On July 12, 2015, the claim was processed and fully denied for the reason B85 – not covered without an approved authorization. On May 19, 2016, the claim was resubmitted but was not accepted for the reason 1066 – claim does not meet timely filing requirements.

The HAP system did not generate an Explanation of Benefits (EOB) Statement because the claim was processed as provider liability with no member responsibility....

...[Petitioner] requested that HAP pay the claim for \$390. We informed [Petitioner] that the claim was processed correctly by HAP. Dr. [REDACTED] billed for an office visit and according to Section 5.2 (a) of the HMO Subscriber Contract, services provided [by] a non-affiliated provider except for an emergency or urgent care or when specifically approved in advance are non-covered services.

Petitioner's Argument

In a letter dated July 10, 2016, submitted with the external review request, the Petitioner's wife provided a detailed explanation of her husband's November 2014 medical care:

My husband had the surgery, we paid our portions of the many bills, constantly trying to work through the bills associated with this surgery. We had NO idea that this bill was not paid. While talking to the HAP representatives regarding this bill, I found out that this bill was not even submitted by Dr. [REDACTED] until 2015, and that they submitted it many times before they billed us. I DID NOT RECEIVE A BILL FOR THIS until 2016. When I called HAP, to try to figure out why this wasn't paid, the claim was investigated, and was determined that my husband had an office visit, rather than being seen at the hospital emergency room, and that we didn't have an authorization to go for an office visit. My point is that, we did exactly what HAP told us to do, that we went to Urgent care, and then Urgent care, referred us to Dr. [REDACTED], who was the attending emergency room doctor, and he determined that we needed to meet him at the office because of the severity of the condition, and the need for his specialized machines. We believed that we were following the protocol of HAP, and HAD NO IDEA THAT WE NEEDED ANY AUTHORIZATION AT THIS TIME, because he was the emergency room doctor. We did not just pick a doctor out of the phone book, and ask for an office visit, ON A SUNDAY, were following the instructions of the doctor, in a very difficult, and very

scary situation. We were terrified my husband was going to lose the sight in his eye. So, the HAP representative suggested that I get a letter from the attending emergency room doctor (Dr. [REDACTED]) from that day, stating what happened, and then file an appeal, which is exactly what I did. After receiving the letter from Dr. [REDACTED], I wrote a short letter, and filed the Appeal with HAP on June 19th, 2016.

I receive a letter on July 1st, 2016, stating that the time to file an appeal had exceeded the 180 days in which I could have appealed the decision. This is the problem; by the time I received the bill from Dr. [REDACTED] which was on 4/12/16, the time for an appeal had already passed. I had no idea that there was a time limit, as the HAP representative did not tell me, when she suggested that I file an appeal, that there even was a time period that I had to do this. So, when I received this letter, I call HAP, and was told that there wasn't anything I could do at this time, other than pursue this avenue of an independent external review.

Finally, we had no idea that this bill was still out there, we had no idea that it wasn't paid, and we were extremely startled to receive a statement from Dr. [REDACTED] office this past April. I tried to resolve this as soon as I realized this hadn't been paid. I called HAP, I called Dr. [REDACTED]'s office, and it took some time to find out chronologically what had happened, I did everything that a reasonable, conscientious, responsible individual would do to resolve payment of this bill. Dr. [REDACTED] and his entire staff were amazing, and worked diligently with us and HAP, during this very trying and scary time. He deserves to be paid. I believe with all my heart that we did everything that HAP asked us to do, and we worked within the guidelines as we understood them....

Director's Review

In resolving this appeal, the Director addresses the two arguments presented by HAP in support of its coverage denial: the timeliness of the Petitioner's appeal and the nature of the claim for the medical services provided by Dr. [REDACTED] on November 16, 2014.

The timeliness of Petitioner's claim

HAP asserts that the Petitioner's claim was not submitted within the time period required by its *Subscriber Contract*. According to HAP, June 29, 2015 was the date they first received a claim for Dr. Beck's November 16 services. The claim was rejected

because the services were provided without prior authorization from HAP. (HAP does not dispute that Dr. ██████ claim was filed within the required time limit.)

There is no evidence in the record that the Petitioner himself was provided with notice of the rejection. The Petitioner's wife asserts that the first time they were aware of HAP's coverage denial was in 2016 when they were contacted by Dr. ██████ office. Given the length of time that passed between the date the services were provided and the date the Petitioner first learned of the denial, it was entirely reasonable for the Petitioner to believe that the claim for the November 16, 2014 services had been submitted and paid by HAP.

HAP claimed in a July 1, 2016 letter to the Petitioner that they had sent him a notice called an "Adverse Benefit Determination" on July 12, 2015. No such document was provided by HAP to the Director. HAP subsequently acknowledged in an August 3, 2016 email to DIFS that, while the claim was denied on July 12, 2015, no denial letter or other notice was issued to the Petitioner.

The Director concludes that HAP's failure to provide the Petitioner with any information about coverage for the November 16, 2014 services precludes HAP from denying coverage because the Petitioner failed to timely file a claim for those services.

The prior authorization requirement

HAP states that it also rejected the claim for the November 16, 2014 medical services because the claim was for an office visit with a non-affiliated provider without prior authorization from HAP.

HAP issued to Dr. ██████ a document titled "Remittance Advice" which detailed HAP's claims processing for Dr. ██████ services on November 16 and 19, 2014. For the November 16 services, the Remittance Advice identifies two services, classified by CPT code,¹ provided by Dr. ██████: 99204 (Office or other outpatient visit) and 92225 (Ophthalmoscopy, extended, with retinal drawing).

If these were the codes used by Dr. ██████ to describe the services he performed, it would be understandable that HAP would not consider the services to be emergency treatment. However, by the time HAP addressed the Petitioner's 2016 claim and appeal, there had been a series of communications between the Petitioner, Dr. ██████,

1. Medical care is classified according to a numerical coding system compiled by the American Medical Association and published in its manual, *Current Procedural Terminology*. The codes in this manual, usually five digit numbers, are commonly referred to as "CPT codes" or "procedure codes" and are used by providers and others to describe medical services when claims are submitted to insurers.

and HAP describing the Petitioner's actual medical condition on November 16, 2014. These letters clearly establish that the Petitioner was experiencing a medical emergency. The sudden onset of a detached retina requiring prompt surgery is certainly an emergency medical condition as that term is defined in the *Subscriber Contract*. The *Subscriber Contract* (pp. 39-40) provides the following definition:

Emergency or Emergency Medical Condition means a medical condition that starts suddenly and includes signs and symptoms so severe, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health or to a pregnancy in the case of a pregnant woman, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. Emergency services are Medically Necessary services provided to diagnose, treat and stabilize an Emergency Medical Condition. Emergency services end when your Emergency Medical Condition is stabilized.

Dr. [REDACTED], in his 2015 claim, may have classified his November 16, 2014 services as an office visit. However, in 2016, when the Petitioner's claim was filed, it had been made clear to HAP that the actual medical care rendered on November 16 was emergency care. The Petitioner's wife has provided a detailed narrative of what occurred and, in a May 19, 2016 letter, Dr. [REDACTED] explained the emergency nature of the services he provided.

The *Subscriber Contract* (page 10) describes the coverage provided for emergency services:

We cover Emergency Services whether received within or outside of the HAP Service Area subject to the limitations of this Section.

- a. Emergency services are services provided to diagnose, treat and stabilize an Emergency Medical Condition. Emergency services end when your Emergency Medical Condition is stabilized.

The *Subscriber Contract* (page 24) excludes coverage for services from "a non-Affiliated Provider, except for an Emergency or Urgent Care...." Thus, emergency treatment does not require prior authorization. This limitation on a prior authorization requirement appears in both the *Subscriber Contract* and the Michigan Insurance Code, MCL 500.3406k, which provides:

...An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization not being given by the insurer before emergency health services were provided.

The Director finds that HAP's denial of coverage for Petitioner's November 16, 2014 emergency services is inconsistent with the terms of HAP's *Subscriber Contract* and Michigan law.

V. ORDER

The Director reverses HAP's denial of coverage. HAP shall immediately provide coverage for the services the Petitioner received from Dr. [REDACTED] on November 16, 2014. See MCL 550.1911(17). HAP shall, within seven days of providing coverage, furnish the Director with proof it implemented this order.

To enforce this order, the Petitioner may report any complaint regarding the implementation to the Department of Insurance and Financial Services, Health Care Appeals Sections, at this toll free telephone number: (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 Michigan 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director