

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 103782-001

v

Health Alliance Plan of Michigan
Respondent

Issued and entered
this 15th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 23, 2009, XXXXX, on behalf of her minor son 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.* On March 30, 2009, after a preliminary review of the material submitted, the Commissioner accepted the request.

The Commissioner notified Health Alliance Plan of Michigan (HAP) of the external review and requested the information used in making its adverse determination. The material was received on March 26, 2009.

The Petitioner exhausted HAP's internal grievance process. The Petitioner's request for external review followed HAP's final adverse determination dated January 27, 2009. In the final adverse determination, HAP informed the Petitioner that since he had failed to timely file a request to proceed to the second level of the internal grievance process, it was upholding the decision it made following the first level grievance. That decision, dated October 8, 2008, explained HAP's reasons for denying coverage.

The issue in this external review can be decided by an analysis of the HAP subscriber contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner, born August 8, 2005, was diagnosed with plagiocephaly (malformation of the skull). His neurosurgeon, XXXXX, MD, prescribed a DOC Band, a type of cranial remodeling helmet. The Petitioner obtained the device in 2006 from XXXXX in XXXXX, Ohio. XXXXX is not part of HAP's network of affiliated providers. The DOC Band cost \$2,900.00.

The Petitioner requested coverage for the DOC Band and HAP denied the request. When the Petitioner appealed, HAP agreed to provide coverage for the helmet based on its network fee schedule. The Petitioner, however, wants the device covered at 100%.

III ISSUE

Did HAP properly deny coverage for a DOC Band under the terms of the subscriber contract?

IV ANALYSIS

Petitioner's Argument

The Petitioner was 13 months old when he was diagnosed with occipital flattening, especially on the right side. His mother notes that he has significant asymmetry of the face and misalignment of the ears. His cephalic index was 97.32% compared to the normal of 75%.

The Petitioner's mother said, "If left untreated, [the Petitioner's] deformity could later affect the functions of his jaw, hearing, breathing and vision. The deformity could also cause other medical complications including ear infections, migraine headaches, and facial pains related to TMJ problems resulting from cranial asymmetry." The DOC Band helmet was seen

as an alternative to surgery.

According to the Petitioner, services were sought from HAP providers but none offered customized helmets to correct plagiocephaly and so his neurosurgeon prescribed the DOC Band helmet. The Petitioner was advised that he would not benefit from other cranial helmets because they were not effective for treating infants his age; most of the devices were for children 3 - 6 months old and were not used by children older than one year.

The Petitioner's mother says it was important to start correcting the cranial deformity as soon as possible because of the Petitioner's age – time was running out. Therefore, she decided to purchase the DOC Band, driving to Ohio for consultations and paying for the helmet herself.

HAP agreed to provide coverage based on its fee schedule and pay \$1,024.00 of the \$2,900.00 total cost. However, the Petitioner argues that coverage should be at 100% since in-plan resources were not available.

HAP's Argument

HAP initially denied coverage, saying the services were available from an affiliated provider and the information provided was not sufficient to demonstrate the need for services from a non-contracted provider. However, HAP later agreed to pay \$1,024.00 in accordance with its professional fee schedule for orthotics.

HAP contends the Petitioner failed to meet the coverage criteria for cranial orthotics in its Benefits Administration Manual (BAM), which includes these provisions:

1. A cranial orthosis will be covered for Members meeting the following criteria:
 - a. Member's medical record must show documentation of one of the following:
 - i. Post surgical correction of cranial synostosis or plagiocephaly
 - ii. Positional plagiocephaly not responding to a minimum of 3 months of conservative therapy, including:

A. Repositioning

B. Physical therapy if congenital torticollis present

2. Members must be between the ages of 4 months and 18 months
3. The DME/P&O rider is not required for coverage.
4. Orthosis must be ordered by an Affiliated or Contracted Neurosurgeon
5. Orthosis must be supplied by an Affiliated or Contracted DME/P&O Provider

HAP believes its determination of benefits was appropriate.

Commissioner's Review

There is no dispute in this case that a cranial helmet was medically necessary for the Petitioner. Furthermore, there is no dispute that cranial orthotics are a covered benefit under the terms of the Petitioner's coverage (see BAM provision above). The issue in this case is whether the Petitioner and HAP have complied with the terms of their health care agreement.

HAP is a health maintenance organization (HMO). A fundamental premise of HMOs is the centralization of health care delivery within a network of approved providers. HMOs contract with providers to furnish services at negotiated rates, thus containing costs. If an HMO member uses a non-affiliated provider when services are available from an affiliated provider, payment for the service may be greatly reduced or even denied entirely. HAP's subscriber contract puts this premise into effect under "Exclusions and Limitations" in Section 5 (p.17):

The following are not covered under this Contract:

* * *

5.2 Other Exclusions

(a) Services provided by a non-Affiliated Provider, except for an Emergency or Urgent Care or when specifically approved in advance by HAP or its designee. [Underlining added]

From the record it is clear that the Petitioner received services (the DOC Band helmet) from a non-affiliated provider without advance approval from HAP. The Petitioner was referred by his primary care physician (PCP) to Dr. XXXXX for an evaluation and Dr. XXXXX prescribed

the DOC Band helmet on September 11, 2006. In a letter dated September 25, 2006, HAP's designee, XXXXX, denied Dr. XXXXX's request for authorization of the DOC Band from a non-affiliated provider. However, the Petitioner had already acquired the device on September 23, 2006, from XXXXX.

The Petitioner reasonably argued that time was of the essence. His mother felt that further delay would only reduce the chance of a successful outcome and that, because of his age, she needed to acquire the cranial helmet quickly after Dr. XXXXX prescribed it. Nevertheless, HAP had not approved the service from a non-affiliated provider before the service was provided as the subscriber contract requires.

The Petitioner also argued that it was necessary to receive service from a non-affiliated provider because the service was not available from an affiliated provider. HMOs are required by Chapter 35 of the Insurance Code of 1956 to have a sufficient number of affiliated providers to assure the availability of covered services. Section 3530 of the Code, MCL 500.3530, says in part:

(1) A health maintenance organization shall maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay. * * *

(2) If a health maintenance organization has an insufficient number or type of participating providers to provide a covered benefit, the health maintenance organization shall ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

Thus, an HMO member must be permitted to obtain covered benefits from a non-affiliated provider if the benefit (or service) is not available from an HMO's contracted provider.

HAP asserted several times (including in its October 8, 2008, denial) that the services were available from affiliated providers. The Petitioner says he was first referred by his PCP to an affiliated provider, XXXXX. However, XXXXX was unable to provide the service the Petitioner needed (HAP does not dispute this). According to the Petitioner's mother, XXXXX

was the only affiliated provider to which they could have been referred. This assertion might be correct because the Commissioner found nothing in the record to establish that there were in fact other qualified providers – nothing that was submitted by HAP gives the name of any affiliated provider besides XXXXX (and perhaps explains why HAP was eventually willing to cover the DOC Band helmet according to its professional fee schedule). However, there is not enough information in the record for the Commissioner to conclude with certainty that the services the Petitioner required were not available from an affiliated provider.

Under the terms of the subscriber contract, services provided by a non-affiliated provider (other than emergency or urgent care) are not covered unless approved in advance. The Petitioner did not have approval. After Dr. XXXXX requested coverage of the DOC Band in September 2006, the Petitioner should have waited for HAP's response before proceeding with services from a non-affiliated provider (HAP did respond, with a denial, on September 25, 2006). Concededly, time was short but HAP's internal grievance process includes a 72-hour expedited procedure.¹ Furthermore, the grievance process would also have given the Petitioner the opportunity to make the argument that needed services were not available from an affiliated provider.

Considering the foregoing, the Commissioner concludes that HAP's offer in its October 8, 2008, letter to pay \$1,024.00 of the charge is a reasonable resolution of this matter. The Commissioner accepts HAP's January 27, 2009, final adverse determination which incorporates by reference HAP's October 8, 2008, denial and includes HAP's offer to pay \$1,024.00 if it is accepted by the Petitioner.

V ORDER

The Commissioner upholds HAP's January 27, 2009, final adverse determination which includes by reference HAP's offer to cover \$1,024.00 of the cost of the DOC Band.

¹ The Patient's Right to Independent Review Act also provides for an expedited external review.

To enforce this Order, the Petitioner may report any complaint regarding payment 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 the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.