

**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. 104523-001

v

Health Alliance Plan of Michigan  
Respondent

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**Issued and entered  
this 22nd day of July 2009  
by Ken Ross  
Commissioner**

**ORDER**

**I  
BACKGROUND**

On April 27, 2009, XXXXX, on behalf of his minor daughter 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 May 4, 2009, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Commissioner notified Health Alliance Plan of Michigan (HAP) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Regulation received the information on May 13, 2009.

The issue in this external review can be decided by an analysis of the 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

Petitioner is a member of HAP. Her health care benefits are defined in the HAP *HMO Subscriber Contract and Rider 037 Mental Health and Chemical Dependency Additional 15 Inpatient Day Rider*.

Petitioner has been diagnosed with obsessive compulsive disorder. She received inpatient treatment at XXXXX in XXXXX, Michigan on two occasions. XXXXX is in the HAP provider network. More recently, she received inpatient treatment at XXXXX in XXXXX, Wisconsin, a provider that is not in HAP's network. Petitioner received outpatient treatment both before and after her treatment at XXXXX and XXXXX. Her inpatient care is detailed below:

<u>DATE</u>	<u>EVENT</u>	<u>ADMISSION LENGTH</u>
12-8-07	Admitted to XXXXX	
12-14-07	Discharged from XXXXX	6 days
12-30-07	Admitted to XXXXX	
1-15-08	Discharged from XXXXX	16 days
4-10-08	Admitted to XXXXX	
8-26-08	Discharged from XXXXX	138 days
1-20-09	Admitted to XXXXX	
5-11-09	Discharged from XXXXX	111 days

The first three admissions described above were covered by HAP. On November 24, 2008, the Petitioner requested authorization for the most recent treatments at XXXXX. HAP denied the request. Despite the denial of coverage, the Petitioner returned to XXXXX.

The Petitioner appealed the denial through HAP's internal grievance process and received HAP's final adverse determination letter dated April 3, 2009.

## III ISSUE

Did HAP properly deny the Petitioner coverage for inpatient treatment at XXXXX from January 20, 2009, through May 11, 2009?

#### IV ANALYSIS

##### Petitioner's Argument

The Petitioner's parents contend the Petitioner is not able to obtain the same level of treatment from HAP's network providers that she has received at XXXXX. In a March 9, 2009, response to HAP's denial of coverage, Petitioner's parents wrote:

As outlined in our first appeal to HAP of January 9, 2009, [Petitioner] has regressed and is unable to manage her mental and physical health due to the very strong Obsessive Compulsive Disorder (OCD) that controls most of her fundamental thinking and behaviors. . . . In HAP's reply, Dr. XXXXX reviewed medical reports from XXXXX and indicated that inpatient psychiatric treatment for [Petitioner] is an appropriate level of care and authorized XXXXX in XXXXX, Michigan.

Most recently, [Petitioner] has received extensive outpatient care . . . in the HAP system through the XXXXX Psychiatric Care Unit with Drs. XXXXX and XXXXX, therapist XXXXX and in home care from XXXXX, XXXXX (September 2008-January 2009). Even with this high level of outpatient care, [Petitioner] regressed to her present condition. [Petitioner's] treatment specialists do not feel that XXXXX can offer the type of care that can improve [Petitioner's] condition.

We have inquired many times in the Health Alliance Plan system regarding the availability of specific treatment needed to control [Petitioner's] Obsessive Compulsive sickness. The previous and current HAP recommendation is XXXXX Hospital, XXXXX, MI. [Petitioner] has been a patient at XXXXX twice. XXXXX was successful in managing a crisis situation, but not successful in improving her severe OCD condition. Even [Petitioner's] doctor there, Dr. XXXXX supported us in our request to obtain treatment at XXXXX.

Petitioner's parents say several health care professionals support their request for treatment at XXXXX including XXXXX, Petitioner's school psychiatrist, XXXXX, an educational therapist of XXXXX, and XXXXX, MD, from the University of Michigan Hospitals and Health Centers. In a letter dated February 18, 2009, Dr. XXXXX wrote:

[Petitioner] previously made significant improvements while at XXXXX, so that we advised she could benefit from further intensive inpatient treatment of her OCD. XXXXX is able to provide medication management as well as develop a cognitive behavioral therapy plan specifically tailored to her symptoms, which would not be available at other acute care hospitals. In addition, XXXXX is an inpatient facility that specifically treats OCD

and OC spectrum disorders, which is an integral step in helping to restore [Petitioner's] level of functioning and provide relief from her symptoms.

### Respondent's Argument

In its April 3, 2009 final adverse determination issued to the Petitioner, HAP referenced two provisions in Petitioner's benefit package (certificate of coverage and related riders):

- Section 4.11 – Coverage is provided for 45 days of inpatient care for acute mental illness.
- Section 5.2(a) – Services from providers not affiliated with HAP are excluded from coverage unless approved in advance.

Applying these provisions, HAP denied coverage for the services because “the provider is not HAP affiliated, the services were obtained without the appropriate authorization from HAP, and the services being requested exceed the coverage allowed under your policy.” HAP also informed Petitioner that “your benefit for mental health services is limited to treatment for acute, short term mental health conditions or for acute aggravation of an on-going condition. . . . During the Committee hearing, your parents indicated that the average stay at XXXXX is three months.”

### Commissioner's Review

In a PRIRA review, the Commissioner evaluates an HMO's claim denial on two grounds – whether the denial is consistent with Michigan law and whether the claims denial is consistent with the terms of the certificate of coverage.

Chapter 35 of the Michigan Insurance Code details the obligations of an HMO to provide essential health care services to its members. Section 3530 is the provision in chapter 35 that addresses the issue presented in this case. Section 3530(1) provides that an HMO must “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.” The covered service in this case is inpatient mental health treatment. Inpatient mental health care is available to Petitioner at XXXXX. Treatment there is available without delay. Therefore, HAP's

provider network does meet the statutory requirement for the health care at issue in this case.

Petitioner's argument is that XXXXX does not provide the same care as XXXXX. However, ranking the care provided by facilities in different states is a difficult task and beyond the scope of this PRIRA. XXXXX does offer child and adolescent inpatient care that includes individual psychotherapy, medication management, and individualized treatment plans. XXXXX is part of the XXXXX Health System, one of the largest health care provider systems in Michigan. XXXXX does have sufficient resources to meet the requirements of the Michigan Insurance Code and HAP's coverage provisions for inpatient mental health treatment.

The HAP mental health rider describes Petitioner's inpatient mental health coverage:

**Inpatient Mental Health Services**

Coverage of inpatient care for acute mental illness is limited to 45 days per benefit period when approved by HAP or its designee. A new benefit period will begin and additional days of care will be available only when there has been a lapse of at least 60 continuous days between the last date of discharge and the next date of admission.

**(1) Mental Health Day Treatment Services**

Intensive date [sic] treatment programs may be covered in lieu of inpatient mental health services, when approved by HAP or its designee. Two days of intensive day treatment are counted as one inpatient hospital day toward the 45-day per benefit period maximum for inpatient mental health services treatment.

Petitioner was eligible for inpatient mental health care when she was admitted to XXXXX on January 20, 2009, because more than 60 days had elapsed since she had been discharged from her previous inpatient treatment.

HAP's certificate of coverage provides coverage for inpatient care for acute mental illness. An "acute" illness is one which has a rapid onset and is not prolonged. This term contrasts with a chronic, or long-lasting, illness. (A chronic condition, according to the National Center for Health Statistics, is a condition lasting for three months or longer.) By January 2009, HAP had provided coverage for inpatient and outpatient mental health treatment for Petitioner for more than a year. By early 2009, Petitioner's treatment could no longer be characterized as

acute care. The HAP certificate and rider provide coverage only for acute inpatient mental health care.

While the Commissioner can certainly understand that Petitioner's parents want the best treatment for their daughter in a situation that presents very difficult treatment questions, the Commissioner cannot find that HAP acted inconsistently with its certificate of coverage or the law.

**V**  
**ORDER**

The Commissioner upholds HAP's April 3, 2009, final adverse determination. HAP is not required to cover Petitioner's inpatient treatment at XXXXX from January 20, 2009, through May 11, 2009.

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.