

**STATE OF MICHIGAN**  
**DEPARTMENT OF LABOR AND ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE SERVICES**

**Before the Commissioner of Financial and Insurance Services**

**In the matter of**

**XXXXX**

**Petitioner**

**File No. 84863-001**

**v**

**Physicians Health Plan of Mid-Michigan  
Respondent**

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**Issued and entered  
This 28<sup>th</sup> day of November 2007  
by Ken Ross  
Acting Commissioner**

**ORDER**

**I  
BACKGROUND**

On September 4, 2007, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On September 11, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request.

The case required analysis by a medical professional. Therefore, the Commissioner assigned the matter to an independent review organization (IRO) which submitted its recommendation to the Office of Financial and Insurance Services on September 25, 2007.

**II  
FACTUAL BACKGROUND**

The Petitioner, born XXXXX, 1991, is a member of Physicians Health Plan of Mid-

Michigan (PHP) as an eligible dependent under her father's coverage. Her health care benefits are defined in PHP's certificate of coverage (the certificate).

The Petitioner was diagnosed with anorexia nervosa in February 2007 and from February 8 through May 11, 2007, received inpatient treatment for her condition at XXXXX in XXXXX. XXXXX is not part of PHP network of contracted providers.

The Petitioner requested coverage from PHP for the services. PHP denied the request and the Petitioner appealed. The Petitioner completed PHP's internal grievance process and PHP (through United Behavioral Health, its mental health benefit delegate) sent a final adverse determination letter dated July 6, 2007.

### **III ISSUE**

Was PHP's denial of coverage for inpatient mental health services from an out-of-network provider correct?

### **IV ANALYSIS**

#### **Petitioner's Argument**

In February 2007 the Petitioner was admitted to XXXXX's pediatric intensive care unit (PICU) in critical condition. According to XXXXX, MD, director of the PICU, she had lost 30% of her body weight, she was hypothermic, her heart rate was in the low 30s, and she had lost essential vitamins and electrolytes. Her family was told that she was days away from going into a coma.

The Petitioner was in the PICU for four days and after she was stabilized, her parents were advised that she needed immediate inpatient treatment from a facility that specialized in severe eating disorders. Since time was of the essence and XXXXX came highly recommended by her network providers, the Petitioner's parents contacted XXXXX. They also looked into other facilities, all out-of-network, and when they inquired about the closest one (in

Wisconsin), it did not have any openings. They also contacted United Behavioral Health about in-network facilities.

Over the telephone, XXXXX did a brief history and determined, based on the Petitioner's medical condition, that she was a high risk. XXXXX told the family that an immediate opening was available and shortly thereafter they were on an airplane to XXXXX.

Those most closely involved in the Petitioner's care supported the decision to seek care at XXXXX as both medically necessary and the only appropriate choice. Dr. XXXXX, on February 13, 2007, wrote in part:

[The Petitioner] clearly could not return to failed outpatient therapy and, through case management and discharge planning, we found a place for the child in Arizona. There is no place for this child here in Michigan. I do not believe, however, that the case managers consulted first with PHP to find out to which facility they would have preferred the child be admitted.

There is absolutely no question for any of us who were engaged in taking care of this child that she needed to be institutionalized. In fact, to return her to an outpatient regimen I think, could have cost her life. I hope this letter suffices to make a case for an inpatient facility.

XXXXX, a registered dietitian who specializes in the treatment of eating disorders, recommended out-of-state treatment on February 14, 2007:

I am often asked which facility in our area is best for in-patient treatment. Unfortunately, the answer is, we do not have a treatment facility, with a good track record for treating eating disorders in the state of Michigan. Forest View, at one time was a premier facility, but over the past ten years has shifted its focus away from eating disorders to a more psychiatric/substance abuse facility. I personally, do not know any health professional who would send their own child to Forest View for treatment of eating disorders.

\* \* \*

I believe it is in [the Petitioner's] best interest to attend a program such as XXXXX in XXXXX so she can work on her recovery in a program designed for adolescents with eating disorders.

XXXXX, PhD, a licensed clinical psychologist, expressed her opinion in a letter dated February 19, 2007:

I initially met with [the Petitioner] and her parents...for an intake on Friday, February 2, 2007. I honestly must say, that in my 25 years of working in the mental health field, I have never been more concerned about a patient's physical health as when I met [the Petitioner]. She wore a ski hat (for warmth), and her clothes (which were already quite tiny) were just hanging from her body. Her face was pale, her eyes sunken with dark rings underneath, and her cheekbones protruded from her face. Her hands were red and blotchy, and she walked and spoke at a strikingly slow pace [sic]. She sat almost motionless, with absolutely no change in facial expression. Her mood was profoundly depressed, and she met all criteria for both a major depressive episode and a severe case of Anorexia Nervosa. She had lost 11 pounds since late December 2006, weighing just 89 pounds at 5' 7" tall. She had not menstruated in more than one year. Her last visit to her primary care physician (the week prior) indicated that her resting heart rate was only 38.

\* \* \*

In cases such as [the Petitioner's], it is imperative that upon medical stabilization, the patient is admitted to a long-term psychiatric facility that specializes in the treatment of Anorexia Nervosa, otherwise relapse is inevitable. Unfortunately, there are no such facilities in the state of Michigan. \* \* \* I recommended that the family seek services from XXXXX ....

\* \* \*

It is my clinical judgment that [the Petitioner] would have quite possibly died from her anorexic condition if medical treatment had not been sought immediately, and if the family had not followed through with appropriate inpatient treatment after her release.

In addition, Dr. XXXXX, the Petitioner's primary care physician, and XXXXX, MD, medical director for XXXXX, also opined that treatment at XXXXX was medically necessary to further stabilize the Petitioner's grave condition.

It is the Petitioner's position that treatment at XXXXX was medically necessary and there were no appropriate alternative sources of care within PHP's network of contracted providers.

Physicians Health Plan of Mid-Michigan

In its final adverse determination, United Behavioral Health (UBH), PHP's mental health delegate, said:

[T]he decision of the [grievance] panel is to uphold the previous administrative adverse benefit determination for inpatient mental health benefit coverage, from February 8, 2007 forward, for lack of out-of-network benefits. Review of the medical record and other available information, including supporting letters and the verbal report of the member's providers and parents, who participating in the panel, did not reveal any apparent medical or clinical contraindication to transfer to an in-network facility. The facility and the [Petitioner's] parents appear to have been aware that facility was out-of-network and that the [Petitioner's] insurance lacked out-of-network benefit coverage for inpatient mental health care. This was the member's first inpatient mental health treatment, and in-network beds were available.

PHP cites Section 1(16) of the certificate (pages 22-23), which describes inpatient mental health services:

Description of Covered Health Service	Is Notification Required?	Your Copayment amount	Does Copayment Meet Out-of-Pocket Maximum	Do you need to Meet Annual Deductible?
<p><b>16. Mental Health Services-Inpatient and Intermediate</b> * * *</p> <p><b>Authorization Requirements</b></p> <p>Please Remember that you must call the Mental Health/Substance Abuse Designee at the telephone number listed in our provider directory and get authorization to receive these benefits in advance of any treatment.</p> <p>Without authorization, you will be responsible for paying all charges and no benefits will be paid.</p>	<p><b><u>Network</u></b> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.</p> <p><b><u>Non-Network</u></b> Non-Network benefits are not available.</p>	<p>No Copayment</p> <p>Non-Network benefits are not available.</p>	<p>No</p> <p>Non-Network benefits are not available.</p>	<p>No</p> <p>Non-Network benefits are not available.</p>

PHP says that under the certificate there are no benefits for inpatient or intermediate mental health services from an out-of-network provider. PHP says it also told the Petitioner that inpatient care for eating disorders was available from a network provider.

PHP contends that its denial of inpatient care from an out-of-network provider was consistent with the terms of the Petitioner's coverage and should be upheld.

#### Commissioner's Review

The Commissioner must decide if inpatient care was medically necessary to treat the Petitioner's anorexia nervosa, and if it was, if PHP must cover the treatment she received at the XXXXX. To answer the question of medical necessity, the Commissioner assigned the case to an IRO for analysis and a recommendation. The IRO reviewer is certified by the American boards of psychiatry and neurology with a specialty certification in psychiatry and is in active practice. The IRO reviewer, after reviewing the Petitioner's medical status, said:

The American Psychiatric Association Practice Guidelines for the Treatment of Patients with Eating Disorders, specifically adolescents, outline appropriate patients for inpatient care. Indicators for children and adolescents are weight less than 85% of the individual's estimated healthy body weight, a heart rate near forty (40) beats per minute (BPM), blood pressure less than 80/50, as well as electrolyte disturbances. Several of these clinical indicators were present with [the Petitioner].

The IRO reviewer noted that Dr. XXXXX, Dr. XXXXX, and dietitian XXXXX all recommended inpatient treatment, and concluded: "It is the determination of this reviewer that...residential treatment for the [Petitioner's] condition [was] medically necessary and appropriate."

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the recommendation is afforded deference by the Commissioner since it is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case and finds that inpatient care was required.

PHP gives two reasons for denying coverage. It says that (1) there is no out-of-network coverage for any inpatient mental health services, and (2) care was available from within its network of contracted providers.

Addressing the first reason, the Commissioner notes that a health maintenance organization (HMO) like PHP is required by Chapter 35 of the Insurance Code of 1956 to provide, at a minimum, “basic health services.” MCL 500.3519(3). Inpatient hospital services for mental illness are not included in the definition of basic health services (see MCL 500.3501) and therefore, under state law, an HMO may exclude inpatient mental health treatment entirely or limit its coverage, even when it is medically necessary. PHP offers inpatient mental health services but has chosen to limit that coverage to 45 days per confinement, and each confinement must be separated by sixty days. See Section 1(16) on page 23 of the certificate.

Because PHP has chosen to make inpatient mental health care a covered service, however, it is also bound by Section 3530 of the Insurance Code (MCL 500.3530). That section requires HMOs “to 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.” Section 3530(2) also provides:

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.

The Commissioner concludes that PHP may not apply an absolute ban on all out-of-network inpatient mental health services. It must permit its enrollees to receive treatment from out-of-network providers if it is shown that there are an insufficient number of in-network providers for a covered service, or when an unreasonable delay would result.

PHP’s second reason for denying coverage was that it had in-network providers who could have provided the care the Petitioner needed. The Commissioner disagrees, finding on this record that PHP has not established that it had sufficient in-network providers and that the Petitioner was justified in seeking care from a non-network provider.

PHP, in its September 18, 2007, letter to both the Office of Financial and Insurance Services and the IRO, asserts that services were available from contracted providers. However, that letter does not mention the name of even a single network provider -- it does not make even a prima facie case that appropriate in-network resources were available. Similarly, a letter from UBH dated June 14, 2007, and the final adverse determination of July 6, 2007, refer to in-network facilities without any specificity. The Commissioner cannot reasonably conclude from any of the material that PHP submitted that an appropriate network facility was available. PHP's asseveration that network facilities were available is unsubstantiated.

In contrast, Dr. XXXXX, Dr. XXXXX, and dietitian XXXXX all opined that there were no facilities in Michigan appropriate for the treatment of the Petitioner, and explained their reasons for recommending XXXXX. Moreover, the IRO reviewer said:

It was the clinical opinion of almost every clinician who had worked with [the Petitioner] that the only appropriate place that could provide the level of care and intensity of services to treat her Anorexia Nervosa, as well as save her life, was the facility in XXXXX. The [Petitioner] and the family did follow the advice of the physician, psychologist, dietitian, and all others involved in her case and did go out of network to XXXXX. \* \* \* It was clinically and ethically appropriate for [the Petitioner] to go to XXXXX in XXXXX.

The Petitioner says that she did as directed and contacted UBH for the necessary services. She says she was told that two mental health facilities, XXXXX and XXXXX, were network providers but says that United Behavioral Health did not provide any information about the qualifications of these two facilities or the services they offer.

The Petitioner learned that Forest View only offered general psychiatric treatment with an average length of stay of 4 to 14 days and could not provide the tube feeding the Petitioner required. The Petitioner said Pine Rest was not forthcoming about its services for eating disorders. Nothing in the record (certainly nothing from PHP or UBH) shows that these facilities could have provided the level of care required by the Petitioner. The Petitioner believed that

she had no other choice but to stay at XXXXX; PHP and UBH offered no practicable alternatives.

The Commissioner concludes that PHP did not have sufficient in-network providers for the type of medically necessary covered service that the Petitioner required and therefore the Petitioner was justified in receiving treatment at XXXXX, an out-of-network provider. The Commissioner reverses PHP's final adverse determination as not consistent with Michigan law.

The Petitioner has also asked to be reimbursed for out-of-pocket expenses that are directly attributable to obtaining services at XXXXX, and for reasonable attorney fees incurred in connection with her external review. The Commissioner declines to order expenses or attorney fees since neither are within the Commissioner's authority under the Patient's Right to Independent Review Act.

**V  
ORDER**

The Commissioner reverses PHP's July 6, 2007 final adverse determination. Pursuant to Section 3530 of the Insurance Code, PHP shall authorize and cover the Petitioner's care at XXXXX at no greater cost to the Petitioner than if the benefit were obtained from a participating provider. The coverage shall be limited to the maximum of 45 days per confinement as provided in the certificate of coverage, and subject to any other terms or conditions of the certificate applicable to in-network inpatient mental health treatment.

Respondent shall, within seven days of providing coverage, provide the Commissioner proof it has implemented the Commissioner's Order. To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Services, 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 Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.