

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

v

File No. 109584-001

Physicians Health Plan of Mid-Michigan
Respondent

Issued and entered
this 31st day of January 2011
by Ken Ross
Commissioner

ORDER

I
BACKGROUND

On January 21, 2010, 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 January 28, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request.

Physicians Health Plan of Mid-Michigan (PHP) was notified of the request for external review and, on February 8, 2010, provided the information used in making its final adverse determination.

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

The Petitioner became a member of PHP on December 1, 2008. Her health care benefits are defined in the PHP Certificate of Coverage (the certificate) and PHP's Care Coordination Policy & Procedure subject "Transition /Continuity of Care" (the transition policy).

On December 2, 2008, the Petitioner, 12 weeks pregnant at the time, had her first prenatal care visit with XXXXX Birth Center (XXXXX). From that date through July 30, 2009, she received prenatal, delivery, and postnatal services at XXXXX. XXXXX's charge for this care was \$3,800.00.

XXXXX is not in PHP's network of providers. PHP covered the prenatal and postnatal services from XXXXX at the out-of-network benefit rate and denied coverage for the delivery of the Petitioner's daughter at XXXXX. The Petitioner had asked PHP to cover all the services as network benefits.

In December 2009 the Petitioner submitted a written grievance to PHP appealing its handling of the claims for services at XXXXX. At the conclusion of the internal grievance process the Petitioner received a final adverse determination letter from PHP dated December 29, 2009, upholding its decision.

III ISSUE

Did PHP correctly cover the Petitioner's services from XXXXX?

IV ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner explained her reason for seeking care from XXXXX:

I desired to use a birthing tub, but this piece of equipment is not available in-network. I received care at the XXXXX in order to utilize their birthing tubs during labor & delivery.

The Petitioner wants PHP to cover her services at XXXXX at the network rate because they were not available in the network.

The Petitioner also says she should have been allowed to continue her care with XXXXX under PHP's transition policy for new members.¹ On her November 29, 2009, grievance form, the Petitioner wrote:

Services provided are not available at either local hospital. I also was denied continuation of care with the XXXXX, but the reason for denial was not true. I was over 16 weeks pregnant when we were notified that we were insured w/ PHP. However, it was made retroactive for the month prior to that. So the denial of continuation of care read that I was only 12 weeks upon enrollment, in actuality I was well into my second trimester when we were notified of coverage.

XXXXX, certified nurse midwife, had written on February 17, 2009, in support of the Petitioner's request to receive services at XXXXX:

[The Petitioner] is pregnant and due to give birth in June, 2009. She has been a patient at the XXXXX Birth Center since December 2, 2008 with this pregnancy and for ten months with her first pregnancy and the birth of her child in January of 2007.

I understand that [the Petitioner] has recently enrolled in your insurance program after receiving services from the birth center. Since we have a well established relationship with [the Petitioner], and this is proven to affect birth outcomes, we suggest and request authorization for continuation of care.

The Petitioner believes PHP should provide coverage at the network level for all of her prenatal, delivery, and postnatal care at XXXXX.

Respondent's Argument

In the final adverse determination, PHP explained its decision on the services from XXXXX:

¹ Under the transition policy, new PHP enrollees are permitted under certain circumstances to continue to treat for a period of time with non-network providers with whom they were treating before they enrolled with PHP.

The original decision to deny your request was upheld because the service is available within the PHPMM Network of providers. The pre and post natal claims were processed according to your Non-Network coverage, which has an annual deductible of \$3,000.00 per member and not more than \$6,000.00 per family per calendar year. The covered percentage for pre and post natal services, after satisfaction of the annual deductible, is 60% of eligible expenses according to the terms, conditions, and limitations of your Certificate of Coverage.

The delivery services were originally denied because PHPMM only covers deliveries that occur in an inpatient hospital setting.

In its February 27, 2009, letter, PHP also addressed the Petitioner's claim that she was eligible to continue care with XXXXX under its transition policy. PHP said:

According to the PHPMM policy on Transition/Continuity of Care..., consideration of care for new members exists when the member is in the second or third trimester of the pregnancy. According to our records, you became effective with PHPMM on 12/1/08 and your first visit with XXXXX Birth Center was on 12/2/08. The XXXXX Birth Center indicates you are 12 weeks pregnant, placing you in your first trimester.

PHP believes its handling of the Petitioner's claims was correct. PHP says that the prenatal and postnatal services from XXXXX have not met the criteria for network-level coverage, that the delivery did not meet its criteria for coverage at all, and that the Petitioner does not qualify for care from XXXXX under its transition policy.

Commissioner's Review

PHP is a health maintenance organization (HMO). A fundamental premise of an HMO is the centralization of health care delivery within a network of providers who sign contracts to charge specially negotiated rates. These discounted rates are a primary method of cost containment that ultimately benefits all members. If an HMO member uses an out-of-network provider, then payment for the services is greatly reduced or sometimes excluded entirely, a requirement that is typical of HMO contracts. The certificate clearly establishes that covered services must be received from network providers when they are available.

The certificate (p. 20) is clear that the maternity services the Petitioner received are covered:

15. Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. [Emphasis added]

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

The Petitioner received the services from a non-network provider. Under the terms of the certificate, covered services from a non-network provider are subject to a \$3,000.00 annual deductible and then paid at 60% of PHP's eligible amount. The Petitioner wants the services she received from XXXXX to be covered as network benefits.

The certificate explains the circumstances under which services received from non-network providers are payable as network benefits:

Section 3: Description of Network and Non-Network Benefits

* * *

Health Services from Non-Network Providers Paid as Network Benefits

If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which benefits are provided under the Policy.

Furthermore, Section 3530(2) of the Insurance Code says:

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. MCL 500.3505(2).

Regarding the prenatal and postnatal services, PHP said those services are available from network providers and identified two network physicians, XXXXX, MD, and XXXXX, MD, able to provide them. There is nothing in the record from which the Commissioner could conclude that prenatal and postnatal services were not available from a network provider or that PHP approved those services from XXXXX. Consequently, the Petitioner's decision to choose XXXXX for those services means they will be covered as non-network benefits, subject to the non-network deductible and coinsurance requirements.

The Petitioner's daughter was delivered at XXXXX on June 17, 2009. PHP denied coverage for the delivery on the basis that the care was not received in an approved facility. The certificate (p. 30) has this provision regarding coverage of professional fees for surgical and medical services:

24. Professional Fees for Surgical and Medical Services

Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Under the certificate, professional fees are covered for care that is received in a hospital, skilled nursing facility, inpatient rehabilitation facility, or alternate facility. It has not been shown that XXXXX is a hospital, skilled nursing facility, or inpatient rehabilitation facility. Nor has it been shown that it meets the definition of an "alternate facility" in the certificate (p. 85):

Alternate Facility - a health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.

- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

The Commissioner therefore concludes that the delivery at XXXXX is not a covered benefit under the certificate.

The Petitioner also believes that her care at XXXXX should be covered under PHP's transition policy. The transition policy (p. 2) permits a new PHP member (like the Petitioner) who was being actively treated by a non-network provider to continue to receive services from that provider after joining PHP.² However, the policy says:

4. Transition care decisions are made on a case-by-case basis and the decisions are guided by the following clinical conditions:

* * *

- d. The member is in second or third trimester of pregnancy.

PHP says that the Petitioner was in her twelfth week of pregnancy (first trimester) when she had her first appointment with XXXXX in December 2008. The Petitioner acknowledged that fact but argues that she was in her second trimester in January 2009 when she received membership material from PHP and learned that her enrollment was effective on December 1, 2008. However, PHP has discretion in its application of the transition policy. For new members, the policy says "consideration" will be given to those who are "undergoing active treatment for a chronic or acute condition with a specific course of treatment...." The record does not contain any information that would suggest the Petitioner's prenatal care was anything other than routine.

The Commissioner concludes and finds that PHP's denial is consistent with the terms and conditions of the certificate and related policies.

V ORDER

The Commissioner upholds PHP's December 29, 2009, final adverse determination.

² According to XXXXX's February 17, 2009, letter from XXXXX, the Petitioner had been a patient of XXXXX during her pregnancy and delivery of her first child in 2007.

PHP is not required to provide network coverage for the Petitioner's prenatal and postnatal services or provide any coverage for her delivery services.

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.