

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 114997-001

v

Paramount Care of Michigan
Respondent

**Issued and entered
this 28th day of April 2011
by R. Kevin Clinton
Commissioner**

ORDER

**I
PROCEDURAL BACKGROUND**

On August 12, 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.*

The Commissioner notified Paramount Care of Michigan (Paramount) of the external review and requested the information used in making its adverse determination. The information was received on August 18, 2010.

After reviewing all the information submitted by both parties, the Commissioner accepted the request on August 20, 2010.

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 is a member of Paramount, a health maintenance organization. His health care benefits are defined in Paramount's *Subscriber Certificate and Member Handbook* (the certificate).

The Petitioner had gastric lap band surgery in November 2007 to treat his obesity. A gastric lap band is an adjustable device that is placed around the top portion of the stomach using laparoscopic surgery.

On April 27, 2010, the Petitioner had the lap band adjusted. Paramount applied the total allowed amount for that adjustment (\$427.18) to the Petitioner's \$1,000.00 morbid obesity surgery copayment.

The Petitioner appealed Paramount's decision to apply the charge to the copayment. After he exhausted Paramount's internal grievance process, the Petitioner received its final adverse determination dated July 15, 2010.

III ISSUE

Did Paramount correctly apply the Petitioner's morbid obesity surgery copayment under the terms of the certificate?

IV ANALYSIS

Petitioner's Argument

In an August 11, 2010, letter addressed to the Office of Financial and Insurance Regulation, the Petitioner explained his position:

In the fall of 2007 I . . . had Gastric Lap Band Surgery. . . . I was advised by Paramount Care of Michigan that I would be responsible for a \$1000

deductible.¹ I'm presently paying this off. . . . I continued to lose weight and continued to follow-up with the Doctors as recommended. I had two lap band adjustments and went in for the third adjustment on April 27, 2010. . . .

I had not paid for any office calls of the two prior adjustments. Prior to the April 27th visit I called Paramount and spoke to a rep. I was advised that they would authorize additional adjustments. . . . After my adjustment on April 27th I left the office without any payment required. The office staff said all should be covered as the two prior adjustments were.

I was very upset to learn that Paramount charged me \$427.18 for this third adjustment. I immediately called Paramount . . . [to] ask why. The only explanation I was provided was that as a subscriber I would be charged a second \$1000 Deductible. I tried to explain that I only had one surgery and already had paid the \$1000 deductible for the Lap Band Surgery. . . . I pointed out that no where in my member's handbook was there an explanation that I would be responsible for a second \$1000 deductible for the same procedure I was still being treated for. This made no sense to me. I believe this was very un-fair and I have never been advised or alerted to any policy changes....

The Petitioner believes Paramount must waive the copayment requirement and fully cover the April 2010 adjustment as they did for the prior adjustments.

Respondent's Argument

Surgical treatment of morbid obesity is a covered benefit under the Petitioner's health plan if certain conditions are met. The benefit is described on p. 17 of the certificate:

Morbid obesity surgery (C/L) Surgery for the purpose of weight reduction or control when specifically approved in advance by Paramount as medically necessary for severely obese Members with documented high-risk co-morbidities. Prior authorization from Paramount must be obtained and the surgery must be performed by Participating Providers authorized by Paramount to perform morbid obesity surgery. To obtain authorization, the Member must qualify under Paramount's Morbid Obesity Surgery medical policy. If approved for coverage, services related to this surgery will be subject to a \$1,000 Copayment which does not apply to the Member's annual out-of-pocket limit. [Underlining added]

On p. 15 the certificate explains that "A Copayment/Coinsurance may be required for Covered Services when this notation (C/L) appears." Paramount has chosen to make the morbid obesity surgery benefit subject to a \$1,000.00 copayment. "Copayment" is defined in

¹ The Petitioner refers to a "deductible" but the issue in this case is the application of a "copayment."

the certificate (p. 33):

COPAYMENT is your share of the cost of some Covered Services. It is a specific fixed-dollar amount, such as \$5.00 or \$10.00. Copayments which are for a specific fixed-dollar amount are due and payable at the time services are provided.

In its July 15, 2010, final adverse determination, Paramount denied waiver of the copayment stating in part:

The Administrative Staff's decision is to uphold the decision that the claim was processed correctly according to your benefit plan design. Services related to morbid obesity surgery are subject to a \$1,000 copayment annually. This information can be found in the Member Handbook on page 17 and a copy is enclosed for your convenience. [Underlining added]

It is Paramount's position that the \$1,000.00 copayment for morbid obesity surgery is not a one time charge but renews annually. Paramount also says, contrary to the Petitioner's assertion, that the \$1,000.00 copayment was applied in 2008 to the morbid obesity services the Petitioner received from Dr. XXXXX and XXXXX Hospital (in February, November, and December 2008).

Paramount contends that it correctly applied its allowed amount of \$427.18 for the Petitioner's April 27, 2010, lap band adjustment to the \$1,000.00 morbid obesity surgery copayment for 2010.

Commissioner's Review

Under Section 3515 of the Insurance Code, Paramount is permitted to have copayments for covered services:

A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. MCL 500.3515.

While Section 3515 caps coinsurance at 50% of a health maintenance organization's

reimbursement to an affiliated provider, it places no similar cap on copayments. Thus, it was permissible for Paramount to have a \$1,000.00 copayment for morbid obesity surgery.

The morbid obesity surgery benefit provision, quoted above, is not clear; it is understandable that the Petitioner might have read it and believed there was only a one-time copayment of \$1,000.00. However, the Commissioner concludes that the copayment applies anew each year for services related to the Petitioner's morbid obesity surgery. The provision does not expressly say it is a one-time copayment and, moreover, the provision says that "services related to this surgery will be subject to a \$1,000.00 copayment...." Therefore, Paramount could apply the copayment in subsequent years.

On April 27, 2010, the services the Petitioner received were HCPCS code S2083 (adjustment of gastric band) and CPT code 76942 (ultrasonic guidance for needle placement); there is no dispute that both services were related to the Petitioner's morbid obesity surgery. Furthermore, those services were "basic health services" as that term is defined in Section 3501(b) of the Insurance Code, MCL 500.3501(b), because the Petitioner received either physician services or ambulatory services² or both.

The Commissioner notes that Paramount has chosen to limit the copayment for basic health services. On p. 1 of the certificate it says:

A Copayment/Coinsurance is your share of the cost for Covered Services. The Copayment/Coinsurance for any Basic Health Care Service will not exceed 50% of the reimbursement for that service. [Underlining added]

Paramount's approved amount (i.e., reimbursement) for the April 27, 2010, services was \$427.18. Thus, the Commissioner concludes that the Petitioner's copayment for those services was limited to 50% of that amount or \$213.59.³

² Generally, ambulatory services are health care services provided on an outpatient basis in a facility.

³ In any year, the copayment for each basic health service related to morbid obesity surgery would be limited to 50% until the \$1,000.00 copayment limit had been reached.

The Commissioner finds that Paramount erred when it applied the total approved amount toward the morbid obesity copayment.

V
ORDER

The Commissioner reverses in part Paramount's July 15, 2010, final adverse determination.

Paramount shall re-process the Petitioner's claim for the services on April 27, 2010, and apply not more than 50% of the reimbursable amount of \$427.18 to the Petitioner's morbid obesity surgery copayment.

Paramount shall provide coverage within 60 days of the date of this Order and shall, within seven days of providing coverage, provide the Commissioner with proof it has implemented this Order.

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

R. Kevin Clinton
Commissioner