

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. 117637-001

v

Priority Health Insurance Company
Respondent

Issued and entered
this 20th day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. BACKGROUND

On October 19, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation (OFIR) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On October 26, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Priority Health Insurance Company (PHIC) was notified of the request for external review and on October 25 and October 28, 2010, furnished the information it 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 has group health care coverage through his employer. His benefits are defined in the PHIC PPO insurance policy (the policy) and covers both network and non-network services. Non-network benefits have higher out-of-pocket costs for the Petitioner.

The Petitioner underwent a kidney and pancreas transplant at the XXXXX Hospital in 2002. The hospital is a PHIC “center of excellence” for transplants but is a non-network provider for all other services received by PHIC subscribers.

During an April 2010 visit to XXXXX, MD, at the XXXXX Hospital, it was determined that the Petitioner’s allograft pancreas was dysfunctional. As a result, Dr. XXXXX decided to order a computerized tomography (CT) scan of the Petitioner’s abdomen and pelvis.

On April 13, 2010, Dr. XXXXX submitted a prior authorization request to PHIC for a CT scan to be performed at the XXXXX Hospital. The request was approved on April 14, 2010, and the scan was performed on April 27, 2010. PHIC covered the scan as a non-network benefit.

The Petitioner appealed PHIC’s decision to process the CT scan claim as a non-network benefit. At the conclusion of its internal grievance process, PHIC affirmed its decision in a final adverse determination letter dated October 14, 2010. The Petitioner now seeks a review of that adverse determination from the Commissioner.

III. ISSUE

Did PHIC properly process the Petitioner’s CT scan claim as a non-network benefit?

IV. ANALYSIS

Petitioner’s Argument

The Petitioner was aware that the XXXXX Hospital was not a network provider for PHIC and he says he told his doctor that PHIC “would have the CT scan performed at a [network facility].” The Petitioner’s doctor gave him the following reasons why the scan should be performed at the XXXXX Hospital:

- Testing at another facility would call for its medical staff to read and interpret the results thus creating a time delay, and
- Staffers at the XXXXX Hospital would read the CT scan immediately and were prepared to perform a biopsy on the pancreas depending on test results.

The Petitioner says because his transplantations were performed at XXXXX, “it forever ties me to that institution.” He believes it made more sense for the CT scan to be performed at the XXXXX because the network provider “could not accommodate my specialized medical needs.”

The Petitioner argues that PHIC should cover the XXXXX CT scan as an in-network benefit.

Respondent’s Argument

In its final adverse determination, PHIC explained its rationale for denial of coverage at the network benefits level:

Decision:

Uphold benefit application – requested coverage will not be provided. The claims were processed appropriately at the Non-Network Benefit level in accordance with [the Petitioner’s] plan documents.

Claims are processed at the appropriate benefit level based on the provider’s participation status, regardless of circumstances.

Facts:

Priority Health Insurance Company processed the claims to apply charges to the Non-Network Benefit deductible and coinsurance in accordance with the Schedule of Benefits and Insurance Policy which states:

NOTE: You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits enclosed in this Policy.

PHIC also referred to these provisions in the policy:

SECTION 6. Limitations

To receive Network benefits, you may only receive services from a Network Provider.

SECTION 8. Claims Provisions

I. FOR NETWORK BENEFITS AND NON NETWORK BENEFITS:

Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level.

PHIC says it was understood that the Petitioner was authorized for the CT scan at the XXXXX Hospital as a non-network service. Because the scan was performed by a non-network provider, PHIC says the service is subject to the policy's non-network deductible and coinsurance provisions.

Commissioner's Review

Under the terms of the policy, an imaging service such as a CT scan, when performed by a non-network provider, is subject to a \$2,000.00 annual deductible and then paid at 60% of the reasonable and customary charge.¹ The Petitioner wants PHIC to treat the CT scan as a network level benefit.

The policy (p. 8) explains how the plan works:

SECTION 5. Obtaining Covered Services

I. How The Plan Works.

This plan is designed as a Preferred Provider Organization ("PPO") group health plan for your medical benefits. The plan provides a network of medical care providers ("Network Providers") who have agreed to provide services for specified fees. Under the plan, you may choose to use either Network services or Non-Network services (as described in Section 5 of this Policy), at the point in time when Covered Services or Supplies are desired. In order to receive Network services, you are responsible to ensure that the Provider participates in the Network at the time of service.

As a Member in the plan you may obtain medical services directly from a Network Provider, allowing you to receive "Network Benefits." You will be responsible for the Copayments, Deductibles, Coinsurance and any amounts over Reasonable and Customary shown under the heading of "Network Benefits" in the Schedule of Benefits. Generally, Network Benefits will cost you less out-of-pocket than Non-Network

1. In contrast, a CT scan performed by a network provider is subject only to the \$1,000.00 network deductible and a \$150.00 copayment.

benefits. If you receive services from a Non-Network provider you will receive "Non-Network Benefits" (except as otherwise specified in this Policy). You will be responsible for the Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary shown under the heading of "Non-Network Benefits" in the Schedule of Benefits. At any time during your course of treatment, you have the option to return to a Network Provider for medical care. If you do, the plan will cover care by a Network Provider at the Network Benefit level.

To verify the current network status of Network Providers, contact the Provider network number listed on your ID card or detailed in the Network Provider attachment. You are responsible for determining whether a provider is part of the Network before receiving services. ***Unless otherwise specified in this Policy, benefits will be paid based on the network status of the provider as of the day services are received.*** [Emphasis added]

It is undisputed that the XXXXX Hospital was a non-network provider on the day the CT scan was performed. Therefore, under the terms of the policy, the CT scan would be covered as a non-network benefit. The Commissioner finds nothing in the policy or in state law that would require PHIC to treat the CT scan as a network benefit, even if there were sound medical reasons for having it performed by a non-network provider as it appears to be in this case.

The Commissioner therefore concludes and finds that PHIC's decision to process the claim for the CT scan at the non-network benefit level was consistent with the terms and conditions of the policy.

V. ORDER

The Commissioner upholds PHIC's final adverse determination of October 14, 2010. PHIC is not required to provide network benefit level coverage for the CT scan the Petitioner received from a non-network provider on April 27, 2010.

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 60 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