

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

v

File No. 119231-001

Priority Health Insurance Company
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On January 25, 2011, 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 Priority Health Insurance Company (PHIC) of the external review and requested the information used in making its adverse determination. The Commissioner reviewed the information and accepted the request on February 1, 2011.

The issue here can be decided by applying the terms of PHIC's *Preferred Provider Organization Plan*, the policy that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On July 6, 2010, Petitioner began experiencing chest pains. Fearing he was having a heart attack, he went to the emergency room at the XXXXX Medical Center. At the XXXXX, he underwent a series of tests and was placed in observation until he was discharged the next day.

The XXXXX does not participate with PHIC's provider network. PHIC provided coverage, processing the claims as non-network outpatient hospital services. The Petitioner believes the claims should have been covered by PHIC as non-network emergency care.

Petitioner appealed PHIC's handling of the claims through PHIC's internal grievance process. PHIC issued its final adverse determination dated December 9, 2010 upholding its original determination.

III. ISSUE

Did PHIC correctly process the claims for the Petitioner's treatment as non-network services rather than emergency services?

IV. ANALYSIS

Petitioner's Argument

Petitioner says he was kept in the chest pain area of the emergency room overnight and that he never left the emergency area of the hospital during his entire stay. Petitioner argues that, according to his policy, his only monetary responsibility should be a \$100.00 copayment because his medical treatment was received in the emergency room of the hospital.

Respondent's Argument

In its final adverse determination PHIC wrote:

The claim was processed at the Non-Network, Outpatient Hospital Services benefit appropriately in accordance with the Insurance Policy, Schedule of Benefits, and Network Addendum.

PHIC's final adverse determination did not address the Petitioner's argument that his claim should be processed as an emergency medical service. In its position paper submitted for this review, PHIC stated that it "processed the claims in accordance with the way in which they were billed, as outpatient services."

Commissioner's Review

The Petitioner's Schedule of Benefits provides coverage for "emergency room services" received at non-network hospitals. The coverage is described in the policy's schedule of benefits:

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Emergency Room Services	\$100.00 Copayment per visit. (Copayment waived only if you become confined in a hospital as an inpatient). Emergency Room physician, ancillary and special services are Covered in full.	\$100.00 Copayment per visit. (Copayment waived only if you become confined in a Hospital as an inpatient).

It is not clear how PHIC concluded that the XXXXX services were billed as outpatient care. Both the XXXXX billing statements and PHIC’s own “explanation of benefits” form (submitted to the Commissioner by PHIC for this review) identify the CPT code for Petitioner’s care as 99285 which is the code for an emergency department visit. (CPT is an acronym for *Current Procedural Terminology*, which is the title of a manual published by the American Medical Association. The manual lists descriptive terms and code numbers for medical services and procedures performed by doctors. The manual is used for a variety of administrative purposes including insurance billing.) The CPT manual defines code 99285 as:

Emergency department visit for the evaluation and management of a patient which requires these 3 key components within the constraints imposed by the urgency of the patient’s clinical condition and/or mental status:

- **A comprehensive history**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

It is clear from this billing information that the services were related to emergency services and were billed as such. The other services listed in the billing and explanation of benefits were for items ancillary to the emergency room care: lab tests, medicine, observation room, etc. As indicated in the schedule of benefits above, those services are covered in full under the emergency room benefit.

The Commissioner finds that PHIC did not process Petitioner’s claims in a manner consistent with the terms of the Petitioner’s policy.

V. ORDER

The Commissioner reverses PHIC's final adverse determination of December 9, 2010. PHIC shall, within 60 days of the date of this order, provide coverage for the July 6-7, 2010 emergency room services at the non-network emergency care benefit level (\$100.00 copayment). PHIC 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 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