

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. 119707-001

Priority Health Insurance Company

Respondent

Issued and entered
this 8th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On February 23, 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 March 2, 2011.

The issue here can be decided by applying the terms of PHIC's *PPO Insurance Policy*. 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 April 21, 2010, Petitioner became very ill and went to the nearest hospital which was XXXXX in XXXXX. Within hours of her arrival an emergency appendectomy was performed and she was discharged the next day.

XXXXX does not participate with PHIC's provider network. PHIC provided coverage, processing the claims as non-network services. The Petitioner believes the claims should have been paid at the network level because it was treatment of an emergency. Petitioner appealed

PHIC's handling of the claims through PHIC's internal grievance process. PHIC issued its final adverse determination December 22, 2010 upholding its original determination.

III. ISSUE

Did PHIC correctly process Petitioner's claims for her emergency appendectomy as non-network services?

IV. ANALYSIS

Petitioner's Argument

Petitioner argues that she was operated on within hours of going to the nearest hospital. She states coverage should be provided at the network level since there are no network hospitals in XXXXX. The nearest network hospital was the XXXXX. Petitioner states that staff at that facility told her that they would have sent someone in her condition to XXXXX for treatment.

Respondent's Argument

In its final adverse determination PHIC wrote that the Petitioner's claims were properly handled as non-network treatment:

Priority Health Insurance Company processed the claim at the Non-Network Benefit and applied charges to the Non-Network Benefit deductible and coinsurance in accordance with the Schedule of Benefits. . . .

Commissioner's Review

The Petitioner's condition on April 21, 2010 constituted a genuine medical emergency according to the PHIC policy which defines an emergency as "the sudden onset of a medical condition with signs and symptoms of sufficient severity . . . that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health. . . ."

The following policy provisions also apply:

SECTION 5. Obtaining Covered Services

I. How the Plan Works.

. . . 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.

III. Services At The Network Benefits Level and The Non-Network Benefits

Level.

* * *

B. Non-Network Benefits.

. . . You are responsible for those Copayments, Deductibles, Coinsurance and any amount over Reasonable and Customary listed in the Schedule of Benefits. Deductibles, if any, apply to all Covered Services except as indicated on the Schedule of Benefits. You are also responsible for Charges in excess of Reasonable and Customary Charges.

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. . . .

The policy does not require PHIC to provide network-level coverage at a non-network facility, even in emergency situations. The Commissioner finds that PHIC processed Petitioner's claims in a manner consistent with the terms of the policy.

V. ORDER

The Commissioner upholds PHIC's final adverse determination of December 22, 2010. PHIC is not required to provide additional coverage for the treatment she received at XXXXX.

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