

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. 118310-001-SF

v

Wayne State University
Respondent

Issued and entered
this 12th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On November 29, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 and MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on December 6, 2010.

The Petitioner is enrolled for health care coverage under the Wayne State University DMC Care Health Plan. The plan provides health care benefits for employees of Wayne State University and their dependents. Details of the health plan are contained in the "Plan Document and Summary Plan Description" which is provided to covered employees. Automated Benefit Services, Inc., administers the plan.

The issue in this external review can be decided by a contractual analysis. 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 February 3, 2009, the Petitioner had a congested eye and sore throat. She called the XXXXX triage nurse to find where she could go for urgent care treatment and was told to go to XXXXX. She was treated there but her insurance plan denied coverage for both the physician and hospital charges, ruling that her condition was not an emergency. The amount charged for the physician care was \$230.00 and the amount charged by the hospital was \$560.00.

The Petitioner appealed the Plan's denial through its internal grievance process. A final adverse determination was issued September 28, 2010, affirming the denial.

III. ISSUE

Is the Plan required to provide coverage for the Petitioner's February 3, 2009, care at XXXXX?

IV. ANALYSIS

Petitioner's Argument

The Petitioner indicates that she went to XXXXX at XXXXX because she was directed there by the triage nurse at DMC Care for urgent care treatment. Had she not been directed there she would not have gone there. She argues that the staff at XXXXX are agents of her health plan. She believes that Wayne State is responsible for the actions of the representatives at XXXXX. Since XXXXX misled her to believe that her treatment at XXXXX was a covered benefit then her health plan is required to pay for it.

Respondent's Argument

In its final adverse determination, Respondent wrote:

On page 34 of the Wayne State University Summary Plan Description, under the heading "ELIGIBLE MEDICAL, MENTAL HEALTH AND SUBSTANCE ABUSE EXPENSES", the benefit for emergency room charges are specifically described under #12 as "EMERGENCY ROOM VISITS FOR TREATMENT OF AN EMERGENT ILLNESS OR ACCIDENT." This provision, #12, also provides the following, "Covered only for life threatening conditions or conditions which are the result of an accident. Emergency room treatment for a non-emergent illness will not be covered."

The Plan also defines an "EMERGENT ILLNESS" on page 87; "Severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life, or could seriously jeopardize a covered

person's health if not treated immediately.”

Based upon the medical records, the condition for which the patient was treated was not a life threatening condition or an accident; therefore, the service is not an eligible expense under this plan.

The Petitioner was treated at XXXXX at XXXXX. Respondent states that this is part of the emergency department of the hospital that provides quick treatment of minor emergencies such as sprains, cuts, earaches, minor burns and dog bites. The hospital billed revenue code 450 and the physician billed procedure code 99283. Both these indicate emergency room care and not treatment in an urgent care facility. Respondent indicated that neither it nor the third party administrator can tell a medical provider how to bill for the care provided to a patient. Since the Petitioner's care was filed as emergency room care it must be processed as such.

Based upon the medical records, Respondent concluded that the condition for which the Petitioner was treated was neither a life threatening condition nor an accident; therefore, the service is not an eligible expense under the plan.

The Respondent submitted to an outside medical reviewer this question: “Was the emergency room visits [sic] on 2/3/09 for the treatment of an emergent illness as defined by the attached plan language?” The reviewer provided this response:

No. . . . The plan covers emergency room visits for life threatening conditions or conditions which are the result of an accident.

Viral conjunctivitis is typically caused by adenovirus, with many serotypes implicated. The conjunctivitis may be part of a viral prodrome followed by adenopathy, fever, pharyngitis, and upper respiratory tract infection, or the eye infection may only be the only manifestation of the disease. Viral conjunctivitis is a self-limited process. The clinical course parallels that of the common cold. This patient's symptoms of mild conjunctivitis with mild pharyngitis are most consistent with a viral syndrome.

The plan believes that its denial of emergency care coverage for the February 3, 2009 services provided by XXXXX was consistent with the terms of the Plan Description.

Commissioner's Review

The Plan Description provides coverage for both urgent and emergency care. The coverage for urgent care services appears on page 25:

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Center Visit including eligible expenses incurred at the time of the visit and physician visits to your home.	100% after a \$10 service fee per visit per covered person. Service fee will be waived if there is no charge for an office visit.	70% of the DMC Care Fee Schedule of after the deductible

The Plan Description on page 99 defines urgent care center:

A facility that is engaged primarily in providing minor emergency and episodic medical care to a covered person. A board-certified physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic’s facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered an urgent care center, by whatever actual name it may be called. The term “urgent care center” may be interchangeably with the term “minor emergency medical clinic.”

Petitioner went to XXXXX at XXXXX on February 3, 2009, as directed by XXXXX triage for treatment of a congested eye and sore throat. The Petitioner was aware that treatment in the emergency room of the hospital was not needed for these conditions. That is why she called the XXXXX nurse specifically for an urgent care center and went to XXXXX as directed. She believed she was receiving care in an urgent care center not a hospital emergency department.

WSU’s independent medical reviewer concluded that Petitioner’s treatment was not emergency care, but the reviewer did not address whether the services were urgent care as defined in the Plan Description. The services were urgent care as that term is used in the Plan Description.

The Commissioner therefore finds that WSU properly denied coverage for Petitioner’s February 3, 2009 care as emergency treatment, but improperly denied coverage as urgent care treatment.

V. ORDER

The Plan’s final adverse determination of September 28, 2010, is reversed. The Plan is required to provide coverage for the Petitioner’s February 3, 2009 treatment as urgent care. The Plan must provide coverage within 60 days and provide the Commissioner proof of coverage within seven days of the coverage being provided.

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. 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. See MCL 550.1915(1), made applicable by MCL 550.1952(2). 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