

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

**In the matter of**

**XXXXXX**

**Petitioner**

**v**

**File No. 118670-001**

**Physicians Health Plan of Mid-Michigan**

**Respondent**

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**Issued and entered**  
**this 1<sup>st</sup> day of August 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. BACKGROUND**

On December 21, 2010, XXXXX, authorized representative of her adult daughter 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.* On January 3, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request.

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.

On June 1, 2005, Petitioner injured her left foot. She was later diagnosed with other foot problems for which her doctors recommended surgery. In January 2009, she had surgery which proved unsuccessful as her pain returned approximately seven months later. After physical therapy did not improve her condition, she sought treatment with Dr. XXXXX who is not part of the PHP network but who was recommended by her other doctors. Dr. XXXXX performed surgery on Petitioner and PHP provided coverage at the out of network level. Petitioner requested that PHP provide coverage at the network level of benefits. PHP denied Petitioner's request, ruling that network providers were available to treat her condition.

The Petitioner appealed PHP's decision. At the conclusion of the internal grievance process she received PHP's final adverse determination letter dated November 24, 2010.

## II. ISSUE

Did PHP properly deny Petitioner network-level coverage for services administered by a non-network provider?

## III. ANALYSIS

### Petitioner's Argument

In her December 21, 2010, letter of appeal to OFIR, the Petitioner argued that Dr. XXXXX's services should be covered at the network level because he has more experience in performing the procedure than the PHP network specialist.

Dr. XXXXX, who performed Petitioner's first surgery, wrote the following in support of Petitioner's request for treatment with Dr. XXXXX in a letter dated October 5, 2010:

Dr. XXXXX is an internationally known expert in [Petitioner's] problem. He pioneered advancements in surgical care for treatment of her pathology and is a world expert on her problem. I kindly request that you allow an out of network authorization such that [Petitioner] may receive the necessary care from Dr. XXXXX.

The Petitioner's mother does not dispute that there are at least three network providers who are qualified to perform the surgery, but maintains that they went to Dr. XXXXX for his expertise. She contends that Petitioner's chances of having a successful outcome were greater because surgery was performed by the most experienced surgeon. For this reason, Petitioner's mother argues PHP should provide coverage at the network level.

### Respondent's Argument

In its November 24, 2010, final adverse determination, PHP affirmed its original claim decision, stating:

The original decision to deny your request was upheld because the services are available within the PHPMM Network of providers. This decision is based on the following sections of your Certificate of Coverage. A copy of the following information is attached.

- **Section 1: What's Covered - Benefits, Accessing Benefits & Notification Requirements**
- **Section 3: Description of Network and Non-Network Benefits**

You can elect to obtain services from these non-Network providers by using your Non-Network coverage, which has an annual deductible of \$250.00 per member and not more than \$500.00 per family per calendar year. The covered percentage for physician office services and outpatient surgery, after satisfaction of the

annual deductible, is 80% of eligible expenses according to the terms, conditions, and limitations of your Certificate of Coverage. . . .

PHP maintains that its denial of network level benefits was correct.

### Commissioner's Review

The Petitioner's certificate provides for both network and non-network benefits. Care from non-network providers generally comes with higher out-of-pocket costs for the PHP member. (The certificate permits in-network level benefits for treatment by non-network providers for emergency care or when the services are not available from network providers.) The Petitioner has not asserted that the care she sought from Dr. XXXXX was not available within PHP's network. Rather, Petitioner argues that Dr. XXXXX was an expert in the treatment of Petitioner's condition and is the best person to perform the surgery.

PHP operates within a network of providers who sign contracts and agree to accept PHP's negotiated rates. A fundamental premise of an HMO is the centralization of health care delivery within such a network. If an HMO member uses a non-participating provider when services from participating providers are available, payment for the non-participating provider services may be greatly reduced or even excluded entirely by the HMO. In this case, the certificate of coverage does not provide for an exception for the Petitioner's situation.

The Commissioner finds that PHP's denial of coverage at the network level of benefits was consistent with the terms of the certificate.

### **V. ORDER**

The Commissioner upholds PHP's November 24, 2010, final adverse determination. PHP is not required to provide network level of coverage for the non-network services the Petitioner received from Dr. 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.

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R. Kevin Clinton  
Commissioner