

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. 118911-001

v

Physicians Health Plan of Mid-Michigan
Respondent

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

ORDER

I. BACKGROUND

On January 6, 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 Physicians Health Plan of Mid-Michigan (PHP) of the request and requested the information used in making its final adverse determination. The Commissioner received PHP's response on January 11, 2011. On January 13, 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.

II. FACTUAL BACKGROUND

The Petitioner is a member of PHP. He receives group health benefits under the PHP certificate of coverage (the certificate). The certificate provides coverage for both network and non-network services.

The Petitioner was under the care of a doctor for pain in the area of his kidneys. In April 2010 he passed a kidney stone. In order to determine if he had any more kidney stones, his doctor ordered two CT scans of the pelvis, one with contrast and one without (CPT code 72194).

The CT scans were performed at XXXXX Hospital on April 21, 2010. XXXXX is not part of PHP's network of providers and PHP covered the scans as non-network services.

The Petitioner appealed PHP's decision to cover the scans at the non-network level. At the completion of its internal grievance process, PHP upheld its original determination and issued a final adverse determination letter dated November 11, 2010.

III. ISSUE

Did PHP properly provide coverage at the non-network level for the Petitioner's CT scans on April 21, 2010, under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

After having the CT scans, the Petitioner received bills totaling \$1,202.16 because XXXXX is not a network provider. He states a scheduler at his doctor's office told him that coverage inquiries and confirmation would be handled by their office and he believes that PHP should have informed the doctor's office that XXXXX was not a network facility when authorization was requested.

The Petitioner states he would have gone to a network facility for the CT scans if he had known that that full coverage would not be provided by PHP at XXXXX.

Respondent's Argument

In its November 11, 2010, final adverse determination, PHP explained its decision regarding the CT scan claims:

The original decision to deny your request was upheld because the services are available within the PHPMM Network of providers. . . .

* * *

The claims have been processed according to your Non-Network coverage, which has an annual deductible of \$200.00 per member and not more than \$400.00 per family per calendar year. The covered percentage for outpatient hospital services, after satisfaction of the annual deductible, is 80% of eligible expenses according to the terms, conditions, and limitations of you Certificate of Coverage.

PHP states that its processing of the claims was appropriate under the terms of the certificate.

Commissioner's Review

The certificate explains, in "Section 1: What's Covered -- Benefits," that network benefits are available only when services are received from a network provider or facility.¹ The certificate states:

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or Non-Network physician or other provider.

The certificate, in "Section 3: Description of Network and Non-Network Benefits," further explains the consequences of non-network services:

¹ There are exceptions for medical emergencies or when medically necessary care is not available from network providers.

Non-Network Benefits

Non-Network Benefits have higher out-of-pocket costs to you than Network Benefits. . . . Covered Health Services will apply to your Non-Network Benefit if they are:

- Provided by a Non-Network Physician or other Non-Network provider.
- Provided at a Non-Network facility.

The Petitioner does not dispute that he received services from a non-network facility and he does not argue that the CT scans were not available from a network provider. He only argues that both he and his doctor's office were misinformed by PHP about the coverage for the CT scans. He states he did not "choose" non-network benefits and would have had the scans performed at a network facility if he had known that XXXXX was not in PHP's network. He does not believe he should be responsible for payment of the non-network deductible and coinsurance.

PHP disputes the Petitioner's contention. It states² that the Petitioner called its customer service unit on April 1, 2010, and was told that neither XXXXX nor his doctor was in PHP's network. PHP further stated that its customer service representative explained that the non-network services would be subject to a deductible and coinsurance. PHP also indicates that it confirmed with XXXXX that the CT scans would be covered as a non-network benefit. Unfortunately, resolution of this issue cannot be the basis of a decision in this case.

Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan properly administered benefits under the terms of the applicable insurance contract. In this case, the Petitioner received services from a non-network provider and PHP processed the claims as non-network benefits. Resolution of the factual dispute described by the Petitioner cannot be part of a PRIRA decision because PRIRA process lacks the hearing procedures necessary to make findings of fact based on credibility

2 January 11, 2011, response to the Commissioner.

and oral statements. In addition, the Commissioner cannot apply legal doctrines such as reliance, estoppel, or waiver. Those remedies are reserved for the circuit courts of this state to which PRIRA decisions may be appealed.

While the Commissioner is sympathetic to Petitioner's concerns, the certificate is clear that services from non-network providers are covered at the non-network level. The Commissioner therefore finds that PHP's processing of the Petitioner's claims was consistent with the terms of the certificate.

V. ORDER

The Commissioner upholds PHP's November 11, 2010, final adverse determination. PHP is not required to cover the Petitioner's April 21, 2010, non-network services as network benefits.

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