

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████
Petitioner

v

File No. 150739-001

Consumers Mutual Insurance Company
Respondent

Issued and entered
this 7th day of December 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 5, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits through a group plan underwritten by Consumers Mutual Insurance of Michigan. The coverage became effective on September 1, 2014.

The Director notified Consumers Mutual of the request for an external review and asked to submit the information used to make its final adverse determination. Consumers Mutual provided its response on November 9, 2015 and, after a preliminary review of the information submitted, the Director accepted the case for review.

This case presents an issue of contractual interpretation. The Director 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 9 and April 13, 2015, the Petitioner received treatment for her Crohn's disease at ██████████. The charges totaled \$7,778.38. Consumers Mutual applied the full amount to the Petitioner's unmet \$10,000.00 out-of-network deductible.

The Petitioner appealed Consumers Mutual's benefit determination through its internal appeals process. At the conclusion of that process, on October 27, 2015, Consumers Mutual issued a final

adverse determination affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did Consumers Mutual correctly process the Petitioner's claims for treatment at [REDACTED] Hospital?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner wrote:

A representative from the company assured me that treatment I receive at [REDACTED] [REDACTED] would be covered and processed as 'in-network.' Subsequent claims have been treated as 'out-of-network' leaving me with thousands of dollars of medical bills.

I have Crohn's Disease and have been receiving treatment at [REDACTED] since August 2010. During this time I have experienced circumstances where healthcare providers require 'referrals' or 'pre-authorization' when managing my care. Once while transitioning from a traditional BCBS PPO to a Community Blue PPO I was required to go through a process to continue treatment at [REDACTED].

On September 1st, 2014 my employer changed healthcare providers from BCBS to [Consumers Mutual]. In anticipation of that change, in August 2014, I called [Consumers Mutual] to inquire how I could continue receiving treatment at [REDACTED] and how to obtain authorization to do so. I was assured that nothing would change, that my Froedtert claims would be 'in-network' and the [Consumers Mutual] coverage would be "on par with Blue Cross". I was left with the promise that nothing would change for me in terms of healthcare coverage when transitioning to [Consumers Mutual].

I received continued treatment for my Crohn's on February 9, 2015 and April 13, 2015. To my surprise [Consumers Mutual] will not honor their word and are processing the claims as 'out-of-network'.

I do not have the name of the [Consumers Mutual] representative I spoke to in August 2014 as I was left with the impression that I would not need them. Maybe there is a chance that the telephone conversation was recorded? I don't know as [Consumers Mutual] did not indicate in their denial letter.

Respondent's Argument

In its final adverse determination to the Petitioner, Consumers Mutual wrote:

[REDACTED] is an out-of-network non-participating provider. This means that [Consumers Mutual] does not have a contract with this provider and there is no negotiated rate between [REDACTED] and [Consumers Mutual]. Because there is no contract, [REDACTED] charges were processed out-of-network and were applied to your out-of-network deductible.

██████████ is not a network provider. Services received at a non-network hospital are covered by Consumers Mutual but are subject to a non-network deductible. The Petitioner's non-network deductible is \$10,000.00 annually. Because the Petitioner had not met her annual deductible, the full hospital charge was applied to her deductible. This claim processing is consistent with the terms of the Petitioner's certificate of coverage.

The Petitioner argues that a representative of Consumers Mutual assured her in a phone call in August 2014 that ██████████ would be treated as an in-network provider. This statement is not consistent with the terms of the certificate of coverage.

Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether an insurer has administered health care benefits according to the terms of the applicable insurance policy and any relevant state law.

The Director finds that Consumers Mutual processed the Petitioner's ██████████ claims correctly under the terms of the Petitioner's certificate of coverage.

V. ORDER

Consumers Mutual Insurance Company's October 27, 2015 final adverse determination is upheld.

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 Director of Insurance and Financial Services, Health Care Appeals Section, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director