

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. 151201-001

HealthPlus Insurance Company
Respondent

Issued and entered
this 29th day of December 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 8, 2015, ██████████, authorized representative of his ██████████
██████████ (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 under an individual plan underwritten by
HealthPlus Insurance Company (HealthPlus). The Petitioner's health care benefits are defined in
the HealthPlus *Signature PPO Individual Certificate of Coverage* and its related schedule of
benefits.

The Director notified HealthPlus of the request and asked for the information it used to
make its adverse determination. HealthPlus provided its response on December 9, 2015. On
December 15, 2015 submitted additional information, and after a preliminary review of the
material received, the Director accepted the case.

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

In August 2014, the Petitioner was hospitalized for depression and anxiety. When she
was discharged, her doctor recommended she participate in Dialectical Behavioral Therapy
(DBT).

On June 1, 2015, the Petitioner began DBT at the [REDACTED] Center with two providers, [REDACTED] and [REDACTED]. Neither are members of the HealthPlus provider network. HealthPlus provided coverage at the non-network provider level of benefits and applied its approved amount to the Petitioner's unmet non-network deductible.

The Petitioner appealed the benefit decision through the HealthPlus internal grievance process. At the conclusion of that process, on November 5, 2015, HealthPlus issued a final adverse determination affirming its benefit decision. The Petitioner now seeks the Director's review of that adverse determination.

III. ISSUE

Did HealthPlus correctly process the Petitioner's mental health treatment as out-of-network services?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination issued to the Petitioner's parents HealthPlus wrote:

HealthPlus Insurance Company (HPI) staff have reviewed your grievance requesting that services rendered to your daughter...from June 1, 2015 forward, by [REDACTED], LMSW and [REDACTED], LMSW, out-of-network providers, be processed as in-network.... Your case has been reviewed by HealthPlus' Director of Customer Service....She has determined to deny your request.

Her decision is based on your...Certificate of Coverage, **Section VI – Accessing Covered Services**, (6.2) *Provider of Choice*, which states:

- A. *Members may receive Health Care Benefits from any Provider the Member chooses. However, if a Member receives Health Care Benefits from a Non-Preferred Provider, the Member will be responsible for paying higher Copayments, Coinsurance, and Deductibles.*

You indicated that the prescribed treatment for [Petitioner] is not available within HPI's network. We recognize your efforts in seeking an in-network provider to provide services. However, your plan, being a PPO, affords you the option to receive services, or self-refer to, out-of-plan providers at the risk of a higher out-of-pocket expense. PPO plans often include two separate deductibles; In-Network and Out-of-Network. Our records indicate that claims for services billed by [REDACTED], LMSW, have been processed in accordance with HPI's agreement with MultiPlan. Part of this agreement stipulates that MultiPlan will reach out to non-plan providers and negotiate a discounted rate. However, since these providers are out-of-network, negotiated rates apply to your out-of-network benefits. Therefore, claims from [REDACTED] have been processed with negotiated discounted rates toward [Petitioner's] out-of-network benefit.

Petitioner's Argument

In the request for external review, the Petitioner's father wrote:

We are writing on behalf of our minor daughter...who was hospitalized for major depression, anxiety and suicidal ideation in August, 2014. Upon discharge, [she] was referred to a Dialectic Behavioral Therapy center for further individual and group sessions. We began at the [REDACTED] Center on June 1, 2015. There are no in-network providers for this service, but it is a fully covered benefit of our insurance company. HealthPlus does not have an in-network provider option for us to get the care our daughter needs and was referred for. We have done our due diligence in contacting multiple providers, none of which were for adolescents or followed the program prescribed for our daughter.

We are aware that authorization for coverage is given in these circumstances for other prescribed therapies that are only available out of network, such as durable medical equipment. Hence, we are not setting a precedent.

The Petitioner's father submitted additional information about their efforts to locate a network provider, the [REDACTED] Center, and medical literature regarding DBT. He wants HealthPlus to approve coverage to continue therapy at the [REDACTED] Center at the network benefit level.

Director's Review

The HealthPlus *Signature PPO* certificate (pages 27-28) covers medically necessary outpatient mental health services. According to the schedule of benefits, out-of-network mental health services are payable at 50 percent of the allowed or reasonable and customary amount after the \$3,000.00 out-of-network deductible is met, plus excess charges (charges beyond the allowed amount). A covered individual can receive services from any provider but if services are obtained from a non-preferred (out-of-network) provider, the insured is responsible for higher deductible, copayment, and coinsurance requirements. (*Signature PPO* certificate, page 11.)

Petitioner's father argues that before scheduling any appointments with the providers, the Petitioner's family attempted without success to locate a provider to meet her needs. Under the Patient's Right to Independent Review Act (PRIRA), in cases that do not require a medical review, the Director is limited to determining whether an insurer has properly administered health care benefits according to the terms and conditions of the certificate of coverage. See section 11(13)(d) of the PRIRA, MCL 550.1911(13)(d).

The Director finds that HealthPlus correctly processed the claims for the Petitioner's mental health services according to the terms of the HealthPlus *Signature PPO* certificate of coverage.

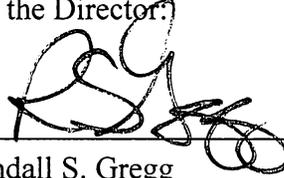
V. ORDER

The Director upholds HealthPlus Insurance Company's November 5, 2015 final adverse determination.

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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:

A handwritten signature in black ink, appearing to read 'RS Gregg', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director