

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. 154397-001

HealthPlus Insurance Company  
Respondent

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Issued and entered  
this 8<sup>th</sup> day of August 2016  
by Randall S. Gregg  
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 30, 2016, ██████████, on behalf of his son ██████████ (Petitioner), filed a complaint with the Director of Insurance and Financial Services and requested 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 plan underwritten by HealthPlus Insurance Company (HealthPlus). The benefits are defined in the HealthPlus *Group Certificate of Coverage*. The Director notified HealthPlus of the external review request and asked for the information it used to make its adverse determination. HealthPlus furnished its response on July 1, 2016. After a preliminary review of the material received, the Director accepted the request on July 8, 2016.

To address the medical issue in this case, the Director assigned it to an independent medical review organization which provided its analysis and recommendation on July 28, 2016.

II. FACTUAL BACKGROUND

From May 19, 2015 to July 20, 2015, the Petitioner received residential treatment at Ascend Recovery Drug and Alcohol Rehab Treatment Center in Utah. (The Petitioner and his family reside in ████████.) HealthPlus denied coverage.

The Petitioner's father appealed the denial through the HealthPlus's internal grievance process. HealthPlus issued a final adverse determination on May 23, 2016 affirming its denial. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did HealthPlus correctly deny coverage for the Petitioner's residential treatment?

### IV. ANALYSIS

#### Respondent's Position

In a letter to the Petitioner's parents dated May 23, 2016, HealthPlus explained its reasons for denying coverage for the inpatient residential treatment:

...It was determined by the Grievance Appeal Committee to uphold the previous denial.

This decision is based on [the] enclosed Schedule of Benefits (SOB); section **Mental Health Services**, which states:

*Limited to Medically Necessary treatment. All services except Outpatient Mental Health and Outpatient Substance Abuse Services require Prior Authorization.*

As you are aware, [HealthPlus] utilizes InterQual criteria in determining medical necessity. InterQual criteria are determined by the patients' presentation at the time, unless a specific time requirement has been identified. Reviewers must select from *Immediate safety risk* or *Potential safety risk* from Clinical Findings; please see enclosed guidelines (Dual Diagnosis).

[HealthPlus] presented this case to an independent review organization (IRO), Medical Review Institute of America (MRIOA), for further analysis. The IRO's physician reviewer, Dr. William Holmes, is board certified by the American Board of Psychiatry and Neurology in General Psychiatry and Child & Adolescent Psychiatry.

The review conducted by the IRO revealed that documentation submitted with the initial request from Ascend Recovery, as well as the documentation you later provided, which included medical records from Ascend and correspondence from some of [Petitioner's] other clinical and/or treating providers established that, based on [Petitioner's] symptoms reported at the time of admission, the InterQual criterion were not met because none of the risk factors to support the use of inpatient rehabilitation were present, including:

- Co-occurring medical condition requiring intensive monitoring
- Protracted withdrawal or history of non-adherence with treatment
- Homelessness and temporary housing unavailable
- No support system
- No positive connection to family/peers
- Inadequate coping skills

Petitioner's Position

In a June 21, 2016 letter to DIFS regarding the external review, the Petitioner's father wrote:

I am contacting you relative to a Level One and Level Two appeal I filed on January 19th, 2016 and May 10th, 2016 for intermediate behavioral health services that my son, [REDACTED], received at Ascend Recovery from May 19th, 2015 to July 20th, 2015. I feel that Health Plus has not acted in an above-board manner. They provided reviews of my appeal in appearance only. It further acted with self-interest in selecting an independent reviewer and selectively providing the information for that review. I am seeking your assistance in ensuring [HealthPlus] acts with good faith and fair dealing in providing coverage for behavioral health services.

\* \* \*

On May 18th, 2016 I received a letter from Health Plus in regards to a phone hearing regarding my Level 2 appeal and [REDACTED] medical necessity for treatment.

My wife and I, along with a trained clinician who is part of a healthcare advocacy group, participated in the phone hearing. Health Plus had nearly a dozen staff members involved in the phone hearing, but only a few of them 'voting' members.

The voting members included the Vice President of Sales and Marketing, the Director of Utilization Management, and the Senior Director of Information Technology and Claims. How can these persons be allowed to render a decision in a patient's medical necessity? How are their judgements more valid than the trained clinician who assisted us, the facility in which [REDACTED] has received treatment, or the medical professionals who recommended residential treatment for my son?

After the phone hearing I received correspondence from Health Plus dated May 23rd, 2016. In the letter they stated that, once again, they were denying the claims because they felt that [REDACTED] did not fit their definition of 'medical necessity'. They also confirm in the letter what positions the voting members held within their company, along with the number of years each of these members had in the insurance industry. These years of experience seem hardly relevant as they are still not trained clinicians.

In the final adverse decision correspondence they state that they presented the case to an independent review organization, Medical Review Institute of America (MRIoA). They state that after review, MRIoA ruled that Andrew did not meet the criteria for 'medical necessity'.

Upon review of the documentation provided, Health Plus electively submitted information only for the dates of May 19th, 2015 to June 8th, 2015. This was only twenty days of his records. This is greatly concerning, not only did Health Plus take away my right to request an external review, they also 'cherry picked' the information that the external review board was presented.

In addition, the Petitioner's father also submitted letters from the Petitioner's psychiatrist and a licensed clinical psychologist attesting to the need for treatment at Ascend Recovery.

### Director's Review

The HealthPlus certificate of coverage, on pages 22-23, provides coverage for medically necessary mental health and substance abuse treatment when preauthorized by HealthPlus. To determine if the Petitioner's residential treatment at Ascend Recovery was medically necessary the Director assigned this case to an independent review organization (IRO) as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO reviewer is a physician who has been in active practice for more than 18 years and is board certified in child and adolescent psychiatry. The reviewer is familiar with the medical management of patients with the Petitioner's condition. The IRO report included the following analysis and recommendation:

[T]his case involves a now 21 year-old male who has been diagnosed with depression not otherwise specified, generalized anxiety disorder, rule out post-traumatic stress disorder, cannabis use disorder, early, full remission, hallucinogen use disorder, early, full remission, Amphetamine-like use disorder (Adderall), early, full remission and opioid use disorder, early, full remission. At issue in this appeal is whether it was medically necessary for the member to have been treated at a residential level of care from 5/19/15 to 7/20/15.

\* \* \*

The member's psychiatrist at the residential program in dispute documented that he was not suicidal or homicidal and did not engage in self-harm. The psychiatrist's notes consisted of documentation of discussing with the member the need to retry medication to keep him stable. However, it appears that this effort was not successful and that the member never consented to take medication.

[A] review of the records from the residential treatment program shows that the member was cooperative with his treatment team, even though he did not always agree with their point of view ... T]here is no evidence that the member ever needed 24 hour monitoring to prevent him from harming himself or others during this admission ... [T]he member was capable of

performing all his own activities of daily living and was an active participant in his treatment.

[U]tilizing the American Society of Addiction Medicine Criteria, the member did not meet the published criteria for a residential level of care during the period at issue in this appeal ... [T]he member was not acutely intoxicated, but had achieved remission of his substance abuse prior to admission. (Dimension 1.) The member had no concurrent medical problems. (Dimension 2.) ... [T]he member was not at risk at all of harming himself or others ... [T]he member had less than moderate impairment in social functioning and no impairment in self-care ... [T]he member had achieved sobriety in the past, so his history did not predict instability without 24 hour supervision. (Dimension 3 ... [T]he member was now open to recovery by the time he was admitted to the residential program and did not need intensive motivating strategies in a 24 hour structured setting to address a minimal amount of treatment engagement. (Dimension 4.) ... [T]he member was an adult who had the legal ability to sign himself out of treatment at any time, but chose to remain in the program voluntarily ... [T]here was no compelling evidence that the member was unable to control his substance use and avoid serious impairment without 24-hour structure. (Dimension 5.) ... [T]he member's home did not pose a threat to his recovery. (Dimension 6.) The American Academy of Child and Adolescent Psychiatry (AACAP) guidelines state only the following with regard to substance abuse disorders: "Residential treatment might be indicated to treat adolescents with substance abuse disorders when the chronic nature of their problems has failed to respond to IOP or PHP." ... [T]he member was never treated at the intensive outpatient program or partial hospitalization program level of care, so he does not meet the AACAP criteria for the residential level of care ... [T]he member could have been treated at a lower level of care during the period at issue in this appeal ... [I]f it was felt that the member needed additional support to maintain sobriety, he could have been referred to a sober living facility, for example, while receiving treatment at a lower level of care.

Pursuant to the information set forth above and available documentation...it was not medically necessary for the member to have been treated at a residential level of care from 5/19/15 to 7/20/15.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b).

The IRO's analysis is based on extensive experience, expertise, and professional judgment and is not contrary to any provision of the Petitioner's certificate of coverage. MCL

550.1911(15). The Director can discern no reason why the IRO's recommendation should be rejected in the present case.

The Director finds that the residential treatment the Petitioner received from May 19, 2015 to July 20, 2015, was not medically necessary to treat the Petitioner's condition and therefore is not a covered benefit.

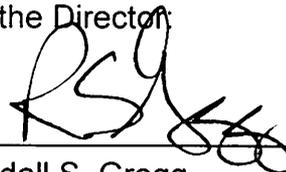
**V. ORDER**

The Director upholds HealthPlus Insurance Company's 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