

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. 154508-001

McLaren Health Plan,

Respondent.

Issued and entered
this 29th day of July 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. BACKGROUND

██████████ (Petitioner) was denied coverage for a genetic test by his health plan, McLaren Health Plan (McLaren or MHP), a health maintenance organization.

On July 8, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits through an individual plan with McLaren. The Director notified McLaren of the request and asked for the information it used to make its final adverse determination. The Director received McLaren's response on July 13, 2016. After a preliminary review of the material submitted, the Director accepted the request on July 15, 2016.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Director 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's health care benefits are defined in a certificate of coverage (the certificate) issued by McLaren.

The Petitioner has attention deficit disorder. On November 4, 2015, he had a genetic test called GeneSight. According to its developer, the test is “a laboratory developed pharmacogenomic assay to help healthcare providers determine the right medication for individual patients suffering from neuropsychiatric disorders, including major depression, ADHD [*attention deficit hyperactivity disorder*] and pain.” The test was performed by Assurex Health, a nonparticipating provider, and the charge was \$4,524.00.

McLaren denied coverage, saying that authorization had not been obtained before the test was performed. The Petitioner appealed the denial through McLaren’s internal grievance process. At the conclusion of that process, McLaren issued a final adverse determination dated June 7, 2016 affirming its denial. The Petitioner now seeks the Director’s review of that final adverse determination.

III. ISSUE

Did McLaren correctly denial coverage for the Petitioner’s genetic test?

IV. ANALYSIS

Respondent’s Argument

In its final adverse determination to the Petitioner, McLaren explained its decision:

The McLaren Health Plan Appeals Committee has carefully reviewed the appeal request on June 7, 2016 for the above mentioned member requesting authorization for genetic testing, which was filed by AssureRx [*sic*] Health, Inc., on behalf of the [Petitioner] on May 18, 2016.

* * *

After reviewing the documentation provided, McLaren Health Plan is unable to approve this request. The reason for the denial is based on the following: Genetic testing requires prior authorization. The Certificate of Coverage ... indicates that we cover medically indicated genetic testing when they are preauthorized. A request for authorization was not received prior to services being rendered. The information provided for review did not list the reason for testing nor did the information indicate how the treatment plan would be affected following testing.

Petitioner’s Argument

In a letter dated July 22, 2016 that was submitted for this external review, the Petitioner wrote:

I would like to provide additional information toward this grievance with McLaren Health Plan. I have included a letter from my doctor explaining why the test was order[ed], as well as the results and outcome it had on my treatment. I have also included what McLaren Health Plan says my current health plan covers.

Dr. [REDACTED] is listed as a Reward's Member doctor.¹ Under my plan, I am allowed to see this provider with no co-pays, deductibles, or coinsurance payments needed. It is reasonable to believe that if I am seeing a McLaren participating provider, and one that is also a Rewards provider, that testing done by that provider would also be covered under my health insurance plan. There is nothing in the material provided to me by McLaren that states I, as the patient, am responsible to get pre-authorization for any laboratory testing provided by an authorized, participating doctor's office (this was stated by McLaren as one of the reasons why the claim was denied). This would be an unreasonable burden placed by McLaren on its subscribers / clients. This would normally be done by the provider's office.

I have been told by customer service representatives of McLaren Health Plan that claims can also be denied if the participating provider sends the test, laboratory specimen, etc. to a non-participating center, lab, or doctor for interpretation. I do not feel this is a reasonable burden to be placed on me as a subscriber to their health plan. It is not reasonable or just to place on me the burden of assuring my participating provider also uses participating labs, etc. It is the decision of the health care provider to use the resources they feel would give them the best results.

I pay over \$16800 a year for health care coverage through McLaren Health Plan. It appears to me that McLaren Health Plan is trying to use loopholes and deceptive practices to deny payment for services it says will be covered under my health plan.

The Petitioner also submitted a July 21, 2016 letter from Dr. [REDACTED] who wrote:

[The Petitioner] has been receiving treatment for Issues of attention deficit disorder. He has been on many medication trials with limited response. He has been compliant with all phases of treatment. GeneSight testing which revealed that he was an ultra-rapid metabolizer of medications and needed to be placed on a drug which blocked an enzyme pathway to help the stimulant medication work better. Without this testing, we would have never been able to determine why he was having such a poor response to medication treatment.

¹ According to the certificate (p. 4), "Rewards Providers" are "a subset of MHP Participating Providers. When you receive services from Rewards Providers, your standard Copayments, Coinsurance and Deductible may be reduced or eliminated."

This treatment was an absolute necessity for [him] and I believe there were no other options available. Subsequently I feel that it should be paid in full by his insurance carrier.

Director's Review

Genetic testing is a benefit under the Petitioner's plan but preauthorization is required. The benefit is described in the certificate (p. 42):

8.23.2 GENETIC TESTING

MHP Covers medically indicated genetic testing and counseling when they are Preauthorized by MHP and provided in accordance with generally accepted medical practice.

The certificate (pp. 20-21) has this provision regarding preauthorization requirements:

8.02. PREAUTHORIZATION

Preauthorization Requirements: Certain services and supplies require Preauthorization by MHP before they will be covered. Part 7, the Schedule of Copayments, Coinsurance and Deductibles and applicable Riders describe in further detail these services and supplies. Participating Providers can assist you in obtaining Preauthorization from MHP. If MHP Preauthorizes a service, we will notify your PCP or the Participating Provider who makes the request.

All Covered Services you receive from a Non-Participating Provider must be Preauthorized by MHP in order to be Covered. A referral from your PCP or another Participating Provider is not enough if you want the services to be Covered.

The GeneSight test was ordered by a participating provider but was performed without preauthorization from McLaren. The certificate, in "Part 9: Exclusions and Limitations" (p. 48), explains that the Petitioner is responsible for obtaining preauthorization:

9.1 Unauthorized Services

Services requiring Preauthorization by MHP will not be paid without such Preauthorization. Although Participating Providers will assist in obtaining MHP Preauthorization, the Member is ultimately responsible for ensuring that any necessary Preauthorization has been obtained.
[Emphasis added.]

In this case, preauthorization was not obtained by the treating physician (Dr. [REDACTED]), the provider (Assurex Health), or the Petitioner. Therefore, the Director concludes that McLaren was correct when it denied coverage for the GeneSight test.

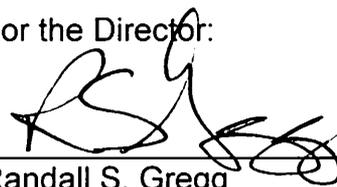
V. ORDER

The Director upholds McLaren'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 sixty days from the date of this order in the circuit court for the Michigan 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:

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

Randall S. Gregg
Special Deputy Director