

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. 145761-001

████████████████████, Plan Sponsor,

and

Magellan Behavioral Health of Michigan, Plan Administrator,
Respondents.

Issued and entered
this 4th day of February 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 12, 2015, ██████████ filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* The Director accepted the request on January 20, 2015.

The Petitioner is enrolled for health care benefits as a dependent through the ██████████ PPO Plan (the health plan), a government self-funded health plan as defined in Act 495. Magellan Behavioral of Michigan (Magellan) administers the plan's mental health and substance abuse programs.¹ The Director immediately notified Magellan of the external review request and asked for the information it used to make its final adverse determination. The Director received Magellan's response on January 14, 2015.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

¹ "Magellan" and "the health plan" are used interchangeably in this Order.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to section 11(7) of PRIRA, MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner has been Medicare eligible since 1999 due to a qualifying disability. She also had primary coverage as a dependent under the health plan while her husband was working. Once her husband retired on May 31, 2014, Medicare became her primary coverage and the health plan became her secondary coverage.

After June 1, 2014, when Medicare became her primary coverage, the Petitioner received outpatient mental health services from [REDACTED] is not an affiliated provider with Medicare and he does not participate with Magellan's network.

The Petitioner paid for [REDACTED] services and then requested reimbursement from the health plan. Magellan, acting for the health plan, covered the services in June 2014 as the secondary payer but denied coverage for the services from July 2 through August 21, 2014,² on the basis that the claims were not sent to Medicare first for consideration as the primary payer.

The Petitioner appealed the denial through Magellan's internal grievance process. At the conclusion of that process, Magellan issued a final adverse determination dated December 19, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Is the health plan required to reimburse the Petitioner for the mental health services she received from [REDACTED] from July 2 through August 21, 2014?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination, Magellan explained to the Petitioner:

We recently conducted a second level claim appeal review for July 02, 2014 to August 21, 2014 for [REDACTED].

² The Petitioner is seeking reimbursement for services through October 31, 2014. However, only the services from July 2 through August 21, 2014, were addressed in the final adverse determination and will be the subject of this external review.

Based on the information reviewed, Magellan has upheld the initial denial based on:

The Coordination of Benefits section of your plan booklet requires that claims for members covered under multiple plans first be submitted to the primary plan(s)/Medicare. Medicare will process the claim and the Medicare Explanation of Benefit (EOB) must be submitted to Magellan to seek reimbursement from the member's secondary insurance through the State of Michigan Employees Plan via Magellan. We in turn will process the claim(s) according to the member's benefit structure. It should also be noted that as a non-participating provider with both Medicare and Magellan, [REDACTED] would be allowed to balance bill the member for any amount not paid by either carrier.

The terms, conditions, and limitation of the applicable plan benefit certificate require: Claims submission to Primary Policy. Please review the plan exclusions of the member's benefit plan description for more information and details.

Petitioner's Argument

In a January 5, 2015 letter accompanying the request for an external review, the Petitioner said:

I am a Medicare recipient. Until my husband's retirement on 31 May, Medicare was my secondary insurer. Much to my surprise, some months later, I found out that it was the primary insurer, and Magellan was my secondary insurer for mental health services. I did not know that the two interfaced. Unfortunately, my therapist had opted out of Medicare, so Magellan would no longer cover me. My therapist and I began the process of termination and finding a new therapist. I had been seeing my therapist for fifteen years, so you can imagine that this was a lengthy process. . . . It has been a difficult 15 years, and the termination had to be handled in such a way that I did not experience even more problems.

Further, Magellan has accepted responsibility for its portion of the charges. In June 2014 they paid my provider \$30.95 for each session. Therefore, they are assuming partial culpability for services.

On two occasions Magellan had denied my claim. I am asking that you reconsider the denials and request that they pay up until the time my termination process was complete.

Director's Review

Neither the Petitioner nor Magellan disputes the fact that Medicare is now the Petitioner's primary health care coverage. Consequently, the claims for [REDACTED] services must be

submitted to Medicare first. Because [REDACTED] is not an affiliated provider with Medicare, it may be that Medicare will pay nothing for his services. Nevertheless, Magellan will not process the claims as the secondary payer until Medicare has first acted on the claims.

There are “explanation of member benefit” statements in the record for the month of June 2014 that show that Magellan did make payments for [REDACTED] care during that month as the secondary payer but Magellan has apparently declined to make any further payments until Medicare has acted on the claims. There is nothing in the record to show that claims for the services from July 2 through August 21, 2014, were submitted to Medicare for processing as the primary payer. It is necessary for those claims to be submitted to Medicare before Magellan will act.

The Petitioner says she is in the process of terminating her therapeutic relationship with [REDACTED], presumably to find a Medicare-affiliated provider, and she wants Magellan to cover her outpatient mental health therapy during the termination process. However, there is nothing in the coverage documents that would require Magellan to continue to act in the role of primary payer under the facts and circumstances here.

The Director concludes that Magellan is not required to reimburse the Petitioner for [REDACTED] services at this time.

V. ORDER

The Director upholds Magellan’s December 19, 2014, 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 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 Department of Insurance and Financial Services, Office of General Counsel, P.O. Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director



Randall S. Gregg
Special Deputy Director