

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. 146247-001

McLaren Health Plan,

Respondent.

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Issued and entered  
this 2<sup>nd</sup> day of March 2015  
by Randall S. Gregg  
Special Deputy Director

ORDER

I. BACKGROUND

On February 9, 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 group health care benefits as a member of McLaren Health Plan (MHP), a health maintenance organization. The Director immediately notified MHP of the external review request and asked for the information it used to make its final adverse determination. The Director received MHP's response on February 13, 2015. After a preliminary review of the material submitted, the Director accepted the request on February 17, 2015.

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 McLaren's *Member Certificate of*

*Coverage Point of Service (POS)*<sup>1</sup> (the certificate). The certificate has two levels of benefits, Option A and Option B. The two options are described in the certificate (pp. 24-25):

#### **8.01 OPTION A BENEFITS**

Option A works like a traditional HMO. Under this option, your PCP [*primary care physician*] coordinates your medical care and issues referrals for specialty care, when needed. All of your health care is provided for the lowest Out-of-Pocket expense to you.

In order to receive Option A Benefits, your PCP must arrange any care not provided by him/her by issuing a referral and, when needed. It is important to obtain a referral from your PCP before you receive specialty care. If no referral is issued, the service is paid under the Option B Benefit and you have more Out-of-Pocket costs.

#### **8.02 OPTION B BENEFITS**

Option B Benefits allows you to self-refer, meaning a referral from a PCP is not required. In addition, you can choose to receive services from any doctor or hospital, whether the provider participates with MHP or not. In exchange for this flexibility, the Out-of-Pocket expenses are higher than under Option A.

If you choose to receive services from a non-participating provider, you may incur costs higher than those received from a participating provider, even if the services are identical. In some cases, you may have to pay the price difference between the cost of the services and what MHP pays a participating provider for the service. These costs can be significant, which is why it is important to understand your liability when using a non-participating provider. . . .

Both Option A and Option B benefits are subject to an annual deductible.

On June 20, 2014, the Petitioner had a preventive (screening) mammogram at [REDACTED] Medical Center, a non-participating provider. The provider's charge was \$430.00. MHP approved \$215.00 for the services and applied that amount to the Option B deductible. Consequently, the Petitioner is being billed for \$430.00 by the provider.

The Petitioner appealed the MHP's payment decision through its internal grievance process, requesting coverage at the Option A level. At the conclusion of the grievance process, MHP issued a final adverse determination letter dated January 5, 2015, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

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<sup>1</sup> Dated January 2011.

### III. ISSUE

Did MHP properly process the claim for the Petitioner's mammogram on June 20, 2014?

### IV. ANALYSIS

#### Petitioner's Argument

In a December 3, 2014, letter attached to her external review request, the Petitioner explained why she was appealing MHP's final determination:

When receiving McLaren Health Insurance in 2011, I checked our Doctors to make sure we were in network and our insurance was accepted. When going to [REDACTED] [Medical Center] for the last 3 years for an appointment, I was not informed that McLaren Ins. was not a participating Ins. Recently, after inquiring about my coverage, it has now been brought to my attention that my service was not covered. My routine mammogram was covered all three years. Why would I expect it would not be covered this year? I never received a bill for my service and there was never an issue. I now have been informed that the bill for \$430.00 for my mammogram is my responsibility and never knew I was out of network as of Nov[ember] 2014.

When speaking to a McLaren . . . representative, I was told [REDACTED] Breast Imaging did not follow up on benefits or changes made to my coverage. Having not been notified by [REDACTED], I was unaware of any changes and considered I was covered since I never received a bill. It was never indicated on my Explanation of Benefits that it was not being paid at the option B benefits. I would not have participated with an out of network facility knowing I was not covered. I feel since I was not informed, the \$430.00 should not be my responsibility. It is very upsetting to be billed for a service that I was not aware of or informed about. I would [have] chosen a different provider and not have all of this confusion for being billed for the procedure.

I would like to have this situation reviewed for reconsideration for an out of network service and process the claim for an in network service.

If you could make an exception for this transaction of \$430.00 to be paid by McLaren Insurance this one time, I will make arrangements for an in network provider.

#### Respondent's Argument

In its final adverse determination to the Petitioner, MHP explained its benefit determination:

The McLaren Health Plan Appeals Committee has carefully reviewed the appeal request for payment of services to [REDACTED] Medical Center at the Option A benefit level. . . which was filed by [the Petitioner] on December 10, 2014.

The Appeals Committee reviewed all of the pertinent information including the appeal letter and claims history. McLaren Health Plan cannot approve this request due to the fact that this provider is not a participating provider with McLaren Health Plan. As stated in the McLaren Health Plan Certificate of Coverage, pages 24 - 25 (attached), if the member chooses to receive services from a non-participating provider they may incur costs higher than those received from a participating provider. In addition, after review of the claim processed for this provider for date of service 6/20/14, it was determined that the claim was processed correctly at the Option B benefit level, according to your summary of benefits.

### Director's Review

The Petitioner wants MHP to cover her preventive mammography as an Option A benefit, which would mean that it would be covered 100% without any cost to the Petitioner (certificate, p. 25). However, the mammogram was performed by a non-participating provider. The certificate (p. 25) indicates that the same preventive mammography a non-participating provider (an Option B benefit) would be covered subject to the deductible and a 30% coinsurance.<sup>2</sup>

The Petitioner says she did not know that [REDACTED] was out-of network:

Having not been notified by [REDACTED], I was unaware of any changes and considered I was covered since I never received a bill. It was never indicated on my Explanation of Benefits. . . . I would not have participated with an out of network facility knowing I was not covered.

But the explanation of benefits statements for the Petitioner's preventive mammograms performed by [REDACTED] in 2012 and 2013 show that MHP's allowed amount was applied to the non-network deductible in those years also. While the Petitioner maintains she had no cost-sharing for the prior mammograms, the explanation of benefits statements show that the mammograms were subject to the deductible, indicating that [REDACTED] was non-participating at least since 2012.

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<sup>2</sup> The federal Patient Protection and Affordable Care Act (PPACA) requires certain preventive care services to be covered without cost sharing, including screening mammography for breast cancer. However, rules promulgated under PPACA permit MHP to impose cost sharing when the required preventive care is performed by a non-participating provider. See 45 CFR § 147.130(a)(3).

At the time of the Petitioner's mammogram on June 20, 2014, [REDACTED] Medical Center was not in MHP's network and the Petitioner had not met her \$2,000 individual Option B deductible. Therefore, MHP correctly applied its approved amount of \$215.00 to the Option B deductible and the Petitioner is responsible for both the deductible and "the price difference between the cost of the services and what MHP pays a participating provider for the service," a total of \$430.00.

The Director concludes and finds that MHP's processing of the claim for the preventive mammogram on June 20, 2014, was in accord with the terms and conditions of the certificate.

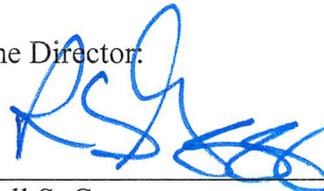
**V. ORDER**

The Director upholds MHP's January 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 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.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director