

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. 147670-001

McLaren Health Plan
Respondent

Issued and entered
this 21st day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 30, 2015, ██████████ (Petitioner) filed a request for external review with the Director of Insurance and Financial Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health benefits through McLaren Health Plan, a health maintenance organization. The benefits are defined in McLaren's *Point of Service* certificate of coverage and *Member Handbook*.

The Director notified McLaren of the request for external review and asked for the information used in making its final adverse determination. The Director received McLaren's response on May 6, 2015. After a preliminary review of the material submitted, the Director accepted the request on May 7, 2015.

The issue here can be decided by a contractual analysis. 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

On November 26, 2014, the Petitioner was transported from the ██████████ ██████████ to the ██████████ by ██████████ ambulance service. ██████████ does not participate with the McLaren Health Plan provider network. Tri Hospital EMS charged \$1,691.75. McLaren paid \$1,353.40, leaving a balance of \$338.35.

The Petitioner appealed the payment determination through McLaren's internal grievance process, requesting that it pay the full submitted charges. At the conclusion of that process, McLaren's issued a final adverse determination letter dated March 18, 2015 affirming its decision. The Petitioner now seeks a review of this determination from the Director.

III. ISSUE

Is McLaren required to pay any additional amount for the Petitioner's ambulance services?

IV. ANALYSIS

Respondent's Argument

In its March 18, 2015 final adverse determination, McLaren wrote:

After reviewing the information provided, McLaren Health Plan is unable to approve this request and the denial has been upheld. The Appeals Committee reviewed all of the pertinent information including the member's appeal letter and explanation of benefits. McLaren Health Plan cannot approve this request as the claim has been paid at the appropriate benefit level. The remaining amount represents "balance billing". Balance billing occurs when non-participating providers choose not to accept McLaren Health Plan's level of payment for services provided. In this case, you are being billed for the difference between the non-participating provider's charge and the McLaren Health Plan approved amount. Please see the Member's Handbook, pages 4 - 5 regarding nonparticipating providers. These claims have been processed according to the member's benefit.

Petitioner's Argument

In a letter of appeal to McLaren dated February 9, 2015, the Petitioner wrote:

I do not agree with your decision not to pay the full amount of the bill submitted to you by **Tri-Hospital EMS**. You have stated this is not covered because it is out of network. **Tri-Hospital** is the only ambulance service in St Clair County and was part of the Port Huron Hospital System. When you took over Port Huron Hospital I assumed it was also part of McLaren. I was not notified or even given a choice as to how I was to be transported to **Karmanos**. Since I was at that time in ICU and taken to the ICU unit in **Karmanos**, I really had no other choice. I would appreciate you looking into this balance owing and pay the remaining amount of \$338.35.

Director's Review

McLaren covers ambulance services at 80 percent of its reasonable and customary amount (after deductible). The Petitioner would like McLaren to pay the full amount of the ambulance bill because she had no other choice than to use an out-of-plan provider. There is no provision in the certificate of coverage or member handbook that would require McLaren to pay more than its reasonable and customary amount. Because the provider does not participate with McLaren they can bill the patient for the difference because, in contrast with a participating provider, [REDACTED] does not have an agreement to accept McLaren's payment as payment in full.

The Director finds that McLaren's benefit determination was consistent with the terms and conditions of the Petitioner's benefit plan.

V. ORDER

The Director upholds McLaren Health Plan's March 18, 2015 final adverse determination. McLaren is not required to pay an additional amount for the Petitioner's November 26, 2014 ambulance services.

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 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, Health Care Appeals Section, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director