

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████
Petitioner

v

McLaren Health Plan
Respondent

File No. 148446-001

Issued and entered
this 13th day of July 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 22, 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 health care benefits as a member of McLaren Health Plan, a health maintenance organization (HMO). The benefits are defined in the *McLaren POS Platinum 1* certificate of coverage for small groups. The Director notified McLaren of the external review request and asked for the information related to the Petitioner's claim.

McLaren provided the requested material. However, in a letter of June 23, 2015 McLaren stated that the Petitioner's initial appeal was not filed timely and, for that reason, his appeal was not eligible for consideration in McLaren's internal grievance process.

The Petitioner argues he received no notice from McLaren that his claim had been denied. He states that in May 2015 he was informed by the hospital that provided the medical services in question that McLaren had declined to fully reimburse the hospital for their services. McLaren has not provided to the Director copies of any letters sent to the Petitioner regarding this claim. (They apparently do not keep copies of such material.) In the absence of clear documentation of when the required appeal material may have been mailed to the Petitioner, the Director accepts the Petitioner's request for external review.

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

On July 16, 2014, while traveling for business in [REDACTED] the Petitioner experienced severe shortness of breath, chest discomfort and was laboring to breathe. He received emergency treatment at the [REDACTED] Medical Center which charged \$3,009.50 for Petitioner's care. The [REDACTED] Medical Center is not a member of McLaren's provider network. McLaren paid \$305.72. The Petitioner is now being billed by [REDACTED] Medical Center for the difference between its charge and the McLaren payment – \$2,703.78.

The Petitioner disagrees with the payment amount and seeks a review from the Director.

III. ISSUE

Did McLaren properly process the claim for Petitioner's July 16, 2014 emergency services?

IV. ANALYSIS

In a letter dated June 18, 2015, accompanying the request for an external review request, the Petitioner explained why he was appealing McLaren's payment decision for his July 16, 2014 services as an emergency visit:

The Emergency Department (ED) visit in question occurred shortly after I arrived in [REDACTED], Utah, on a business trip for ABEM [American Board of Emergency Medicine, the Petitioner's employer] almost a year ago. About five months earlier in January 2014, I had experienced a spontaneous left pneumothorax (approximately 70% collapsed left lung), had a thoracotomy performed and a chest tube placed at the [REDACTED] Hospital ED in [REDACTED]. I was then immediately admitted to [REDACTED] Hospital for four days with the chest tube to re-inflate my left lung. In my hospital discharge instructions, my physician told me that my spontaneous pneumothorax had a 50% chance of recurrence within a year, and I was told to avoid air travel for at least 30 days since air travel could cause a recurrence.

My trip to [REDACTED] was one of my first experiences with air travel following my hospitalization. Upon arriving there, I started experiencing severe shortness of

breath, chest discomfort, and was laboring to breathe, much like I had experienced in January with the collapsed lung. Having been told that my pneumothorax had a 50% chance of recurrence and that it could be prompted by air travel and changes in air pressure, I decided to seek medical attention as soon as possible in case it had recurred.

I first looked into whether any urgent care clinics were available, as I wanted to see a doctor and get an x-ray but had no desire to spend the evening in the ED. By that time of day, however, all of the local urgent care facilities were closed for the evening. So, due to my symptoms and recent medical history, I decided to go to the ED at [REDACTED] Medical Center, where I told them about my symptoms and my recent spontaneous pneumothorax.

After spending several hours in the ED, I was told that my symptoms were likely due to the high altitude in [REDACTED] (approx. 10,000 feet) and not any apparent pulmonary or cardiac issues although, of course, I had no way of knowing that at the time. Given my recent medical history, the severity of my symptoms, the fact that any alternative immediate medical care outside the ED was unavailable, I believe my decision to go to the ED was a reasonable one and that my visit should be processed as an emergent one given the terms of ABEM's policy with McLaren. Given the location, the fact that I had to use an out-of-network provider was unavoidable.

In addition, ABEM's policy with McLaren had an annual maximum out-of-pocket cost for individuals and families covered under the plan. Due both to my above-referenced hospitalization and my wife's ongoing cancer treatment, my family had already paid the maximum out of pocket cost under our policy for 2014.

This all occurred almost a year ago, and for most of that time as far as I knew, there were no issues with McLaren covering my July 2014 ED visit. The first I learned of any problem was from Intermountain Healthcare, owners of [REDACTED] Medical Center, when in February 2015, Intermountain notified me that they were filing a Provider Appeal with McLaren for additional reimbursement beyond the small amount (\$305.72, I think) that McLaren had reimbursed them for my ED visit. They told me that they would keep [me] informed of the status of their appeal to McLaren. I then learned in a letter I received from Intermountain in April that their appeal had been denied, and in May I received a statement from Intermountain for the \$2,553.78 balance.

The "Summary of Benefits" in Petitioner's certificate of coverage indicates that emergency care is paid at 90 percent of McLaren's eligible amount after a \$150.00 copayment.

Although the Petitioner says his emergency care on July 16, 2014 was not covered, the explanation of benefits statement reveals that McLaren paid [REDACTED] medical Center \$305.72. The Petitioner was not assessed a deductible or coinsurance charge, presumably because, as the Petitioner notes, his family had already reached their maximum out-of-pocket limit.

The certificate of coverage, on page 32, describes the coverage for emergency care:

Services for medical emergency or accidental injury, including mental health or substance abuse-related medical emergencies, are Covered when provided by a Participating Provider or non-Participating Provider. However, when services are provided by a non-Participating Provider, the Member will be responsible for any balance bill (the difference between the Reimbursement Amount paid by McLaren Health Plan and the amount of the non-Participating Provider's charges).

McLaren's payment was its approved amount for the treatment the Petitioner received. Had the [REDACTED] Medical Center been an in-network provider, it would have been obligated to accept that amount as payment in full. However, as a non-network provider the [REDACTED] Medical Center has no agreement with McLaren requiring it to accept McLaren's payment as a full payment. Consequently, [REDACTED] Medical Center is free to bill the Petitioner for the balance of its charge.

The Petitioner argues that he has reached his out-of-pocket maximum and, for that reason, should not be required to make any additional payments for his medical care in [REDACTED]. The Summary of Benefits provision referenced by the Petitioner includes this series of questions and answers:

Is there an out-of-pocket limit on my expenses?

Yes [\$2,500 per person, \$5,000 per family for out-of-network care]. The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit?

Premiums, balance billed charges, and health care this plan doesn't cover. Even though you pay these expenses, they don't count toward the out-of-pocket limit.

The Petitioner is being billed by [REDACTED] Medical Center for a balance billed charge, which is not subject to the out-of-pocket limit. The Director finds that McLaren processed the claims for the Petitioner's July 16, 2014 emergency services in a manner consistent with terms and conditions of the *Platinum 1* certificate of coverage and the Summary of Benefits.

V. ORDER

The Director upholds McLaren Health Plan's claim decision. McLaren is not required to pay more for the Petitioner's July 16, 2014 emergency care.

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 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 'RS Gregg', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director