

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. 145404-001-SF

██████████, Plan Sponsor,

and

NGS CoreSource, Plan Administrator,

Respondents.

Issued and entered
this 6th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 15, 2014, ██████████, on behalf of her minor daughter ██████████¹ (Petitioner), 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 Petitioner receives health care benefits as a dependent through a plan sponsored by ██████████ (the plan), a self-funded local unit of government plan subject to Act 495. The plan is administered by NGS CoreSource (NGS). The Director immediately notified NGS of the external review request and asked for the information it used to make its final adverse determination. NGS provided its response on December 18, 2014, and the Director accepted the request on December 22, 2014.

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, MCL 550.1901 *et seq.*

¹ Born May 19, 2001.

This case presents an issue of contractual interpretation. 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

The Petitioner's health care benefits are described in a booklet called the [REDACTED] *Community Schools Medical Benefit Plan Summary Plan Description*² (the booklet) and its amendments.

On April 8, 2014, the Petitioner received emergency care at [REDACTED]. The total charge for this care was \$1,584.00 (\$995.00 for the hospital's facility charge and \$589.00 for the services of physician [REDACTED] [REDACTED] is not in the plan's network of providers.

The plan covered the care at the in-network level, paying 100% of its reasonable and customary (R & C) rate. The R & C rate for the hospital charge was \$796.00 and, after applying a \$200.00 emergency room copayment, the plan paid \$596.00. The plan's R & C rate for the physician services was \$256.20 and the plan paid that amount. This left the Petitioner responsible out-of-pocket for \$532.80 (the \$200.00 emergency room copayment plus \$332.80, the difference between [REDACTED] charge and the plan's R & C rate).

The Petitioner appealed NGS's payment determination through the plan's internal grievance process. At the conclusion of that process, NGS issued a final adverse determination dated October 24, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did NGS correctly cover the Petitioner's April 8, 2014, emergency care?

IV. ANALYSIS

Petitioner's Argument

In an undated letter sent with the external review request, the Petitioner's mother wrote:

On April 8th, I took my daughter . . . to the nearest emergency room for severe chest pains and shortness of breath. We were out of state at the time, so the nearest emergency room was out of network.

² Dated January 1, 2011.

We received two bills for that visit - one from the hospital, and one from the emergency room physician. The bill from the hospital was paid in accordance with my insurance policy. The bill from the physician was not.

The physician charged a total of \$589, and the hospital charged \$995. . . . According to the terms of my insurance policy, I am responsible for \$200 of this total, which I paid to the hospital.

NGS only paid a portion of the \$589 physician's bill, and stated that I was responsible for the balance.

* * *

In their response to my appeal, NGS stated:

"Since the services were rendered by a non-network provider, the charge is subject to the reasonable and customary allowance."

The Petitioner's mother said that according to the booklet, emergency room care from both network and non-network providers is covered 100% after a \$200.00 copayment.

Respondent's Argument

In its final adverse determination, addressed to the Petitioner's mother, NGS explained its reason for denying coverage:

Under the terms of the [REDACTED] Community Schools Employee Benefit Plan, Reasonable and Customary (R&C) refers to certain plan limitations on provider charges, in regard to what will be accepted as allowable under the plan. While the plan has contracted with a Preferred Provider Network (PPO) to pre-arrange negotiated rates with network providers, charges over R&C will be denied for non-network providers and certain aspects of R&C calculations may also still impact what the plan will reimburse on a network claim. In general, R&C means that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered. Reasonable and customary calculations also use standard methods to adjust for unusual circumstances or complications which may require additional time, skill or experience. With in-network professional services (services provided by an individual practitioner), R&C is the fee agreed to by the participating provider as long as your provider adheres to standard billing practices. . . .

It has been confirmed that [your daughter's] emergency room visit on 04/08/14 did not result in an in-patient admission and the \$200 emergency room copay was assessed to the charges incurred at [REDACTED] [REDACTED]. It has also been confirmed that [REDACTED] practice group] is a non-network provider. The plan did consider the charges incurred at 100%. However, since the services were

rendered by a non-network provider, the charge is subject to the reasonable and customary allowance. So, the difference in the charge and the patient responsibility is the amount which exceeds reasonable and customary - and is not covered under the terms of the plan. Therefore, it must be maintained that the original processing of the claim in question was appropriate and no adjustments are warranted.

Director's Review

The third amendment to the plan does say, as the Petitioner's mother asserts, that both network and non-network emergency room care is covered "100% after \$200.00 copay." However, the booklet (p. 9) further explains how the R & C charge may affect out-of-pocket costs when services are received from non-network providers:

"What is Meant By "Reasonable and Customary?"

"Reasonable and Customary" (R&C) refers to certain plan limitations on provider charges, in regard to what will be accepted as allowable under the plan. As the actual purchaser of health care services, you should not hesitate to seek information from medical providers on the cost of proposed treatments for you and your family members, just as you would if you were making any other type of purchase. While the plan has contracted with a Preferred Provider Network (PPO) to pre-arrange negotiated rates with network providers, charges over R&C will be denied for non-network providers and certain aspects of R&C calculations may also still impact what the plan will reimburse on a network claim. By playing an active role in seeking cost information, you can minimize your own out-of-pocket (coinsurance) costs and conserve the dollars applied to any maximums under the plan as well. In general, R&C means that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered. Reasonable and customary calculations also use standard methods to adjust for unusual circumstances or complications which may require additional time, skill or experience.

The booklet (p. 12) also says:

What is A Network Provider?

A network provider is a facility or practitioner who has a signed contract with a preferred provider network (PPO) to provide medical services at a specific rate or pay. . . .

Finally, the booklet has this exclusion (pp. 50, 54):

. . . The following is a list of services which are not covered by any portion of the plan.

70. Reasonable and customary. Charges in excess of those considered reasonable and customary.

Since non-network providers have not agreed to perform services at a specific rate, the provisions above explain that the plan uses an R & C rate to determine what amount the provider should be paid. In this case, the plan determined that the R & C rate for [REDACTED] services should be \$256.20 and it paid 100% of that amount. [REDACTED] was not obligated by contract to accept the plan's R & C rate as payment in full for services and could bill the Petitioner for the difference between her charge and the R & C rate.

It is unfortunate the Petitioner was not aware the plan will only cover what it considers to be reasonable and customary for non-network services. Moreover, the Petitioner's family may not even have been aware that [REDACTED] was not in the plan's network. However, the booklet limits out-of-network benefits to what is reasonable and customary.

The Director finds that the plan covered the Petitioner's emergency physician services according to the terms and conditions of the plan booklet

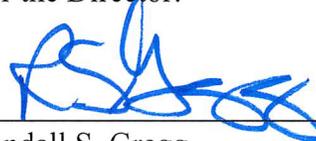
V. ORDER

The Director upholds the plan's October 24, 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 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, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director