

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. 151968-001

Consumers Mutual Insurance of Michigan,
Respondent.

Issued and entered
this 24th day of February 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) believes that her health insurer, Consumers Mutual Insurance of Michigan (Consumers), did not correctly process the claims for services she received in September 2015.

On February 1, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of Consumers' decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives benefits through an individual plan that is underwritten by Consumers. The Director immediately notified Consumers of the external review request and asked for the information it used to make its final adverse determination. Consumers provided its response on February 3, 2016. After a preliminary review of the material received, the Director accepted the request on February 8, 2016.

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 defined in a document called *Certificate of Coverage for PPO Network Plans*¹ (the certificate).

On September 10, 2015, the Petitioner received health care services at [REDACTED] a non-participating (out-of-network) provider. Consumers' allowed amount for those services was \$187.82 and it applied that amount to the Petitioner's unmet out-of-network deductible.

The Petitioner appealed the benefit determination through Consumers' internal grievance process. At the conclusion of that process, Consumers issued a final adverse determination dated December 16, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did Consumers correctly process the claims for the Petitioner's medical services on September 10, 2015?

IV. ANALYSIS

Petitioner's Argument

In a letter dated January 29, 2016, submitted with her request for external review, the Petitioner wrote:

I am requesting external review of my healthcare coverage from Consumers Mutual Insurance of Michigan. . . .

I believe that I was wrongly refused coverage for yearly check up for my multiple sclerosis treatment. The appointment was made a year in advance, and missing the appointment would have resulted in losing my specialty medication that is needed for disease management. Rescheduling the appointment was not a possibility at the time. I requested that the appointment be covered because it was my previously established doctor under the continuation of care. Though the amount was adjusted since my first appeal, I was still responsible for \$187.82. Under my selected plan, the yearly check up was supposed to be fully covered under the chronic disease management (CDM) coverage.

* * *

¹ Effective 1/1/2015.

I believe . . . that I was denied coverage because they were no longer going to be offering coverage in the new year. Though I have no proof of this being the actual reason, as they cite that my established neurologist was out of network, I feel like I was unjustly denied coverage for this extremely important yearly check up.

Respondent's Argument

In its final adverse determination, Consumers explained to the Petitioner how it processed the claims for her medical services:

. . . Our investigation revealed that [REDACTED] and [REDACTED] [REDACTED] are out-of-network nonparticipating providers. This means that [Consumers] does not have a contract with these providers and there is no negotiated rate between these providers and [Consumers]. Because there is no contract, the charges were processed out-of-network and were applied to your out-of-network deductible. . . .

[Consumers] has determined that your claims processed correctly. Therefore, we cannot offer you any additional payment amount. We encourage you to contact your providers regarding the amount charged and your payment responsibility.

Director's Review

The Petitioner scheduled her multiple sclerosis checkup at [REDACTED] a year in advance, before she had insurance coverage with Consumers. She kept that appointment because she wanted to have continuity of care. However, it is undisputed that Spectrum Health Hospital is an out-of-network, non-participating provider. The certificate (p. 5) explains when services are covered at the out-of-network benefits level:

Non-Participating Providers

Covered Services you receive from Non-Participating Providers are covered at the Out-of-Network Benefits Level. You do not need a referral from your PCP to seek most Covered Services at the Out-of-Network Benefits Level. Certain services, listed in Section 5.D, do require Prior Approval from Consumers Mutual before they are covered at the Out-of-Network Benefits Level.

. . . If you do not receive approval from Consumers Mutual prior to seeking Covered Services from Non-Participating Providers, or if we determine the medically appropriate treatment for your condition is available from a Participating Provider, the services will be Covered at the Out-of-Network Benefits Level.

There is no indication that the Petitioner requested or received prior approval from Consumers before her appointment on September 10, 2015. Therefore, according to the certificate's "Schedule of Benefits," those services were subject to an annual \$4,000.00 out-of-

network deductible, which had not been met. There is nothing in the certificate that would require Consumers to reimburse the Petitioner for those services.

The Director finds that Consumers correctly processed the claims for the services from Spectrum Health Hospital according to the terms and conditions of the Petitioner's plan.

V. ORDER

The Director upholds Consumers Mutual Insurance of Michigan's final adverse determination of December 16, 2015.

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, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:

A handwritten signature in black ink, appearing to read 'RSG', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director