

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. 149030-001

UnitedHealthcare Community Plan, Inc.,

Respondent.

Issued and entered
this 18th day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

 (Petitioner) disputes a decision made by UnitedHealthcare Community Plan (UHCCP) in the processing of a claim for emergency services he received. On July 27, 2015, he filed a request with the Director of Insurance and Financial Services seeking an external review of that decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material, the Director accepted the request on August 3, 2015.

The Petitioner receives health care benefits through UHCCP, a health maintenance organization. The Director notified UHCCP of the external review request and asked for the information it used to make its final adverse determination regarding the Petitioner's claim. The Director received UHCCP's response on July 29, 2015, and subsequently received additional information on August 6, 2015.

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 UHCCP's *Gold Compass 500 Individual Medical Policy* (the policy).

On February 27, 2015, the Petitioner was treated in the emergency department of [REDACTED] Hospital. Claims were submitted by the hospital (\$1,307.05) and also by the physician who treated the Petitioner in the emergency department (\$750.00). Neither the hospital nor the physician is in UHCCP's provider network.

After the claims were initially processed, the Petitioner appealed UHCCP's benefit determinations through its internal grievance process. As the result of the Petitioner's internal grievance, UHCCP reprocessed the hospital claim and, in accord with the terms of the policy, paid 80% of the hospital's charge after the \$250.00 "per occurrence" emergency services deductible was satisfied.¹ Therefore, only the claim from the physician remains in dispute.

At the conclusion of the grievance process, UHCCP issued a final adverse determination dated June 30, 2015, upholding its decision on the claim from the emergency room physician. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did UHCCP correctly process the claims for the Petitioner's emergency services on February 27, 2015?

IV. ANALYSIS

It is undisputed that the Petitioner went to a non-network hospital and was treated there by a non-network physician. The Petitioner believes that UHCCP should have treated the physician's claim differently because it was an emergency. In a letter submitted for this external review dated July 9, 2015, the Petitioner explained his complaint:

I went to the Emergency room for an issue that arose that evening, Friday, Feb 27, 2015. . . . The pain was unbearable and I could not sit. There was no way I was going to be able to wait until Monday to see my PCP [*primary care physician*]. Even if I was able to see him, I still would have needed a referral to see a specialist for my condition.

I went to the closest emergency room to my house. It is also the hospital that I have used for the past 20 years. [REDACTED] Hospital in [REDACTED] [REDACTED] is only 10 miles away. A hospital in network would have been [REDACTED] and 24 miles away.

I go to a hospital that is out of network and I understand the billing according to my plan at 80/20. What I do not understand is that the doctors, tests and any other

¹ See explanation of benefits statement dated July 1, 2015.

fees are not covered at all because they are billed separately. These are all considered out of network. This was an emergency.

* * *

What should be fair and just is that for all emergency services, the doctors, testing, etc. are all covered under the hospital plan. In my case 80/20 for all these services also.

According to the policy's schedule of benefits (p. 1), the Petitioner's health plan "offers a limited Network of providers." The schedule of benefits goes on to say:

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

The plan does make an exception for emergency services received from a non-network provider (schedule of benefits, p. 1):

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

The schedule of benefits (p. 18) explains that the plan pays its "eligible expense" for covered emergency services from a non-network provider; it does not say that it will pay the non-network provider's full charge:

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Policy.

The policy has this warning about the use of non-network providers (schedule of benefits, p. 19):

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

In this case, the emergency department physician billed \$750.00. UHCCP determined that its eligible expense for those services was \$149.84 and it paid 80% of that amount (\$119.87) as required by the schedule of benefits (p. 6).² Thus, the Petitioner is responsible for 20% of the eligible expense (\$29.97) plus the difference between the provider's charge and the eligible expense (\$600.16), a total of \$630.13.

It is unfortunate that the Petitioner was seen by a non-network emergency department physician; if he had been treated by a network physician, he would have been responsible only for the 20% of the eligible expense. The Director concludes that UHCCP correctly processed the emergency department physician's claim according to the terms and conditions of the policy.

V. ORDER

The Director upholds UHCCP's June 30, 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 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:



Randall S. Gregg
Special Deputy Director

² See explanation of benefits statement dated March 13, 2015.