

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. 146590-001

United Healthcare Insurance Company
Respondent

Issued and entered
this 26th day of March 2015
by Joseph Garcia
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 2, 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 coverage through a group plan underwritten by United Healthcare Insurance Company. The benefits are defined in the *United Healthcare Choice Plus* certificate of coverage and related riders. The Director notified United Healthcare of the external review request and asked for the information it used to make its final adverse determination. United Healthcare submitted the requested information on March 2, 2015. After a preliminary review of the material, the Director accepted the Petitioner's request for external review on March 9, 2015.

This case presents issues 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

On September 18, 2014, the Petitioner underwent multiple surgical procedures related to endometriosis. The surgery was performed by ██████████ at the O'Connor Building

Surgery Center in San Jose, California. [REDACTED] and the O'Connor Building Surgery Center are not in United Healthcare's network of providers.

The surgeon's fee and the facility fee totaled \$98,100.00. United Healthcare's approved amount was \$6,697.74. United Healthcare assessed a deductible of \$2,893.57 and a coinsurance charge of \$1,141.25. United Healthcare then paid the balance of the approved amount – \$2,662.92. This left the Petitioner possibly responsible to pay the providers \$91,402.26 after paying them the deductible and coinsurance charges.

The Petitioner appealed the payment calculation through United Healthcare's internal appeals process. At the conclusion of that process, United Healthcare affirmed its original benefit decision in a final adverse determination dated January 1, 2015. The Petitioner now seeks a review of that determination from the Director.

III. ISSUE

Did United Healthcare correctly process the claims for the Petitioner's September 10, 2014 surgery?

IV. ANALYSIS

The Petitioner believes that United Healthcare's payment is too small. In its final adverse determination, United Healthcare explained how it determines payments for non-network providers:

Maximum Non-Network Reimbursement Program (MNRP) is an approach to reimbursing non-network physicians, facilities and other healthcare professionals that uses rates and methodologies established by Medicare. MNRP replaces Reasonable and Customary (R&C) processing on plans that utilize MNRP. The MNRP program utilizes the Centers for Medicare and Medicaid Services (CMS) Fee Schedules.

Non-network physicians, other healthcare providers and facilities are free to set their prices for the services they provide and United Healthcare has no control over these billed charges or annual increases. These increases can have a significant impact on the costs for our customers over time.

Your plan defines eligible expenses as the amount that we will pay for covered health services, incurred while the policy is in effect, are determined as stated below.

When covered health services are received from non-network providers, eligible expenses are determined, based on the following applicable criteria, to the extent available, in the order of priority identified below.

1. Fee(s) that are negotiated with the provider; or
2. 110% of the available published rates allowed by Medicare for the same or similar service within the geographic market; or
3. A fee schedule that we develop; or
4. 50% of the billed charge.

Director's Review

The certificate covers benefits based on eligible expenses and the network status of the provider. According to the *Choice Plus* certificate's schedule of benefits (page 1):

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Eligible expenses are defined on pages 27-28 of the Schedule of Benefits as:

the amount we determine that we will pay for Benefits. For Network Benefits you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

* * *

When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on... 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

The Petitioner's outpatient surgery was provided by non-network providers. The Petitioner does not dispute the network status of those providers. Rather, she argues that the amount paid for the services performed is not reasonable. Challenging an insurer's determination of eligible expenses is not a matter which can be resolved in an appeal under the Patient's Right to Independent Review Act (PRIRA) because an insurer's calculation of eligible expenses is not within the Director's regulatory authority. Under the PRIRA, the Director's authority is limited to questions of medical necessity and compliance with the terms of an insurance policy.

The Director finds that United Healthcare processed the Petitioner's surgery claims in a manner consistent with the terms of the *Choice Plus* certificate of coverage.

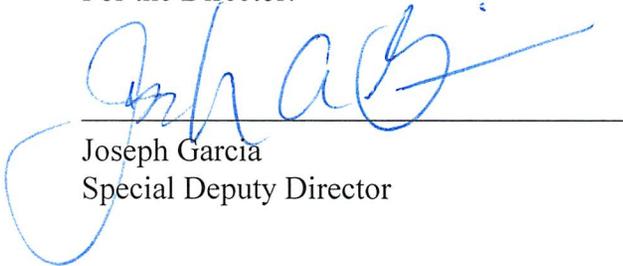
V. ORDER

The Director upholds United Healthcare's January 1, 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 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:



Joseph Garcia
Special Deputy Director