

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. 147748-001

UnitedHealthcare Insurance Company,

Respondent.

Issued and entered
this 28th day of May 2015
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 5, 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.* After a preliminary review of the material received, the Director accepted the request on May 12, 2014.

The Petitioner receives health benefits through a group plan that is underwritten by UnitedHealthcare Insurance Company (UHC). The Director notified UHC of the external review request and asked for the information it used to make its final adverse determination.

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 the *UnitedHealthcare Choice Plus* certificate of coverage, which includes riders, amendments, and notices (the certificate).

On November 18, 2014, as part of an office visit with her network physician, a molecular pathology test was ordered (CPT code 81479). The test was conducted by a laboratory in California that is not in UHC's network. The laboratory's charge was \$2,762.00. UHC allowed \$1,519.10 for the service and it applied that amount to the Petitioner's annual deductible for out-of-network services.¹

¹ UHC said the provider agreed to accept the discounted amount of \$1,519.10 as payment in full for the test. However, the

The Petitioner appealed UHC's benefit determination through its internal grievance process. At the conclusion of that process, UHC issued a final adverse determination dated March 21, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did UHC correctly process the claim for the Petitioner's laboratory services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner's request for external review contained this statement:

I called . . . UnitedHealthcare with a procedure code for a lab test I was going to have performed at my doctor's office on 11-18-14. The insurance representative that I spoke with informed me the test would be covered at 100%. I had the test completed and then I received a billing statement from the lab where my lab work was sent to from my doctor's office stating that they were out of network and I would owe \$200.00. I was never informed anything would be out of network. In fact I was informed it was covered at 100% by my insurance company. I do not believe I should be responsible for this \$200.00 statement for the lab work. I believe my insurance company should be responsible for payment due to the information that was given to me by the representative. If I would have been told that I would have [a] \$200 copay then I wouldn't have had the test completed.

Respondent's Argument

In its final adverse determination, UHC explained how it processed the claim for the laboratory services:

Based on our review, according to your Benefit Plan, under the Section Schedule of Benefits, this request for payment was processed correctly.

Your plan states that Lab, X-Ray and Diagnostics – Outpatient services would be covered at 70% of eligible expenses for Non-network provider after satisfying [your] annual deductible.

Your plan's benefits for these services were processed based on the network status of the rendering provider without regard to the facility where the services were performed or the physician who ordered the service.

Director's Review

The Petitioner had a laboratory test performed and billed by an out-of-network provider. The certificate's schedule of benefits (p. 13) says that outpatient laboratory tests from an out-of-network provider are covered at 70% after the out-of-network deductible has been satisfied. According to UHC, the Petitioner had not met her out-of-network deductible at the time the test was performed.² Therefore, UHC correctly processed the claim when it applied its allowed amount to the deductible.

The Petitioner says a UHC representative, in a telephone call, told her in advance that the test would be covered 100% with no cost sharing. She says if she had known that she would have out-of-pocket expense, she would not have had the test done.

The Director does not know what was said in that telephone call but notes that the test would have been covered 100% with no cost sharing if it had been performed by a network provider. But even if the Petitioner had been given incorrect information, the Director does not have the authority under the Patient's Right to Independent Review Act (PRIRA) to alter or amend the certificate's terms of coverage because of that misinformation. In this review under PRIRA, the Director can only determine if UHC administered benefits consistent with the terms and conditions of the certificate and any applicable state law. The Director concludes that it did.

V. ORDER

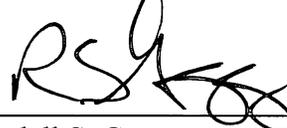
The Director upholds UnitedHealthcare Insurance Company's March 21, 2015, final adverse determination.

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 The certificate's schedule of benefits (p. 4) says the annual deductible for non-network services is "\$6,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family."