

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. 150204-001

United Healthcare Insurance Company
Respondent

Issued and entered
this 27th day of October 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 5, 2015, ██████████, authorized representative of his patient, ██████████ (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 benefits through a group plan underwritten by United Healthcare Insurance Company (UHC). The benefits are described in the *United Healthcare Navigate Plus* certificate of coverage. The Director notified UHC of the external review request and asked for the information it used to make its final adverse determination. UHC furnished its response on October 8, 2015. After a preliminary review of the material received, the Director accepted the request on October 12, 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

On June 15, 2015, the Petitioner was treated in the emergency department of ██████████ Hospital in ██████████ for a corneal ulcer in her left eye. Between June 16, 2015 and July 8, 2015, the Petitioner received seven follow-up office visits with ██████████, a non-network provider. UHC charged the Petitioner a non-network provider copayment for the office visits.

The Petitioner appealed the office visit copayment charges through UHC's internal grievance process. At the conclusion of that process, on August 25, 2015, UHC issued a final adverse determination affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director. The amount in dispute is \$723.00.

III. ISSUE

Did UHC correctly determine benefits for the Petitioner's out-of-network services provided between June 16, 2015 and July 8, 2015?

IV. ANALYSIS

Petitioner's Argument

In a July 21, 2015 letter to UHC, the Petitioner's father wrote:

I am requesting United Healthcare reconsider unpaid claims incurred by my daughter...because I did not get the required referrals needed by my insurance plan.

My daughter...had a serious eye infection. This was an emergency. She was seen at *Henry Ford OptimEyes* for diagnosis and treatment beginning June 14, 2015. Her diagnosis is ulcer of the eye (ICD-9 Code 370.00)....

On June 14th, she was treated by [REDACTED]. On June 15th, she was seen by [REDACTED]. It was explained that these visits were paid by United Healthcare, and applied to my copay.

She was seen subsequently on June 16th, 17th, 19th, 23rd, 25th, July 2nd, July 8th, by [REDACTED]. These charges are outstanding because a referral was required, and by the time I realized this, the 5 back date extension had passed.

It is my hope that United Healthcare will reconsider its decision and pay these claims even though a referral was not in place at the time of service.

Respondent's Argument

UHC's Explanation of Benefits forms show that a copayment was assessed for each of office visits with [REDACTED]. The EOB form included this notation:

If you did not get a valid referral from your primary care physician (PCP) before receiving this service, you may have a lower benefit. If you have met your out-of-pocket or co-insurance maximum your benefits will not change.

In its final adverse determination, UHC explained how it processed the claims for [REDACTED] services:

Your plan states that for in network provider these services are covered at 100% of eligible expenses after you pay a Copayment of \$70 per visit for services provided with a referral from you Primary Physician and 100% after you pay a Copayment of \$120 per visit for services provided without a referral from your Primary Physician.

Director's Review

Page 1 of UHC's *Navigate Plus* Schedule of Benefits states:

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.

The Schedule of Benefits, on page 2, also explains when prior authorization is required:

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, your Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card....

The Petitioner received services from a non-network provider without a referral from her primary care physician. No prior authorization had been obtained from UHC to receive non-network physician services. (The Petitioner's father acknowledges that a referral was not obtained.) Since the required prior authorization was not obtained, and the Petitioner had not met her out-of-pocket maximum for the calendar year, the higher, non-network, copayment was required. (The non-network copayment would normally be \$120.00 but because the provider's full charge was less than \$120.00, only the amount of the provider charge was required.)

The claims were processed in a manner consistent with the Petitioner's benefit plan. The Director cannot require UHC to provide additional coverage.

V. ORDER

The Director upholds United Healthcare Insurance Company's August 25, 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