

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. 152868-001

UnitedHealthcare Community Plan, Inc.,

Respondent.

Issued and entered
this 18th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 25, 2016, ██████████ (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 Director accepted the request on April 1, 2016.

The Petitioner has individual health care coverage through UnitedHealthcare Community Plan, Inc. (UHC), a health maintenance organization. The Director immediately notified UHC of the external review request and asked for the information it used to make its final adverse determination. UHC provided information on April 6, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues under MCL 500.1911(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 UHC's *Silver Compass 250 Individual Medical Policy* including riders, amendments, and notices (the policy).

On September 17, 2015, the Petitioner suffered a ruptured Achilles tendon while playing basketball in Greenville, South Carolina. From September 21 through September 24, 2015, he had surgery and related services to repair the injury from these providers:

Service Dates	Provider	Billed Amount
9/24/15	[REDACTED]	\$ 364.32
9/24/15	[REDACTED]	1,074.70
9/24/15	[REDACTED]	18,369.00
9/21 - 9/24/15	[REDACTED]	2,483.00
	Total	\$ 22,291.02

UHC denied coverage for these services because they were performed by providers who do not participate with UHC's CompassNetwork.

The Petitioner appealed the denials through UHC's internal grievance process. At the conclusion of that process, UHC maintained its denial and issued four final adverse determinations dated February 2, 2016. The Petitioners now seeks a review of those final adverse determinations from the Director.

III. ISSUE

Did UHC correctly deny coverage for the Petitioner's surgery and related services?

IV. ANALYSIS

Petitioner's Argument

In information filed with the external review request the Petitioner wrote:

On September 17, 2015, I suffered a serious foot injury while playing basketball in Greenville, South Carolina, where I was temporarily living while participating in a six-month heart device academic program . . . (I had only been in South Carolina for approximately 2 weeks). Later that day, I was diagnosed with a ruptured Achilles tendon. . . .

Prior to my surgery, my mother and father (my mother, who had driven from Michigan to South Carolina to support me in connection with my injury), and I each were separately advised by the billing department of [REDACTED] and [REDACTED] [REDACTED] (where my surgery was performed) that my surgery to repair my ruptured Achilles tendon would be covered by my United Healthcare insurance. Agents or employees of the Hospital separately assured each of us that my personal financial responsibility for the surgery would be limited to 10% of the total cost based on my coverage. Based on these statements, I had the surgery performed at [REDACTED] [REDACTED] on September 24, 2015. I never would have had the surgery performed at [REDACTED] if I had understood that there was any risk that the surgery would not be covered by my insurance.

On October 8, 2015, I received a notice via email of a claim summary from United Healthcare stating that I was responsible for the entire cost of the surgery, or \$23,000. Needless to say, I was shocked and dismayed given that I and both of my parents had explicitly been told that the surgery would be covered by my insurance policy. . . . I promptly contacted my insurance company to discuss the bill. I spoke with a woman named Catherine in the United Healthcare medical claims department who stated that coverage had been denied because the hospital where the surgery was performed was outside the network. Catherine could not explain why the [REDACTED] employees had told me, my father, and my mother that I would only be responsible for 10% of the cost of my surgery.

On October 14, 2015, I contacted [REDACTED] billing department and spoke with a woman named Alisa who directed me to wait two weeks because the official bill had not been sent out yet and that the problem may resolve itself during that period. After waiting the directed two weeks, I spoke with Alisa again October 29, 2015, at which time she admitted that there had been a mistake and I had been provided with misinformation regarding the coverage for my surgery. Alisa confirmed that, prior to my surgery, a United Healthcare representative had specifically stated to [REDACTED] that my surgery would be covered under my United Healthcare policy. Alisa also stated that if United Healthcare had informed [REDACTED] that my surgery would not be covered, [REDACTED] would have been obligated to inform me that the surgery was not covered by my United Healthcare insurance, and that I was required to pay 100% of the cost "out of pocket." [REDACTED] made no such statement to me. To the contrary, based on information that [REDACTED] received from United Healthcare, I was expressly told that the surgery would be covered under my United Healthcare policy.

Based on the foregoing, I respectfully request that United Healthcare: (i) overturn its position that my surgery falls outside my insurance policy coverage, and (ii) provide coverage for 90% of the bill for the surgery. But for the misinformation that was separately provided to me, my mother, and my father, I never would have elected to have the surgery performed. I did so only based on the express statements to me from Hillcrest via United Healthcare that my surgery would be covered by my policy.

UHC's Argument

In its four final adverse determinations (one for each provider), UHC explained to the Petitioner why it denied coverage:

Greenville Family Medicine Associates:

The assistant surgeon service(s) being appealed processed previously as payment for this service is denied. Benefits are only available when you receive services from a provider in your plan's network and in your plan's network service area. The reason was the provider is out of network with your health plan and your health plan does not offer out of network benefits.

[REDACTED]:

The outpatient facility service(s), services being appealed processed previously is denied. Benefits are only available when you receive services from a provider in your plan's network and in your plan's network service area. The reason was the provider is out of network with your health plan and your plan does not offer out of network benefits.

Debra Kidd, RNA:

The anesthesiology service(s) being appealed processed previously as claim reimbursement includes consideration of the procedure code modifier reported on this claim. The claim incorrectly processed at your network level of benefits. The claim should have denied as not covered because the provider is out of network with your health plan and your health plan does not provide out of network benefits. We will not reprocess the claim at this time.

Brian Weatherby, MD:

The physician service(s) being appealed processed previously as payment for services is denied. Benefits are only available when you receive a valid referral from your primary care physician (PCP) before receiving the service. The claim processed with the incorrect remark code. The claim denied because the provider is out of network with your health plan and your health plan does not offer out of network benefits.

Director's Review

The policy's "Schedule of Benefits" (p. 1) has this notice:

Accessing Benefits

Compass offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a CompassNetwork provider within the Network Area. You can confirm that your provider is a CompassNetwork provider by calling Customer Care at the telephone number on your ID card or you can access a directory of providers online at www.mvuhc.com.

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.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

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.

Thus, according to the "Schedule of Benefits," all health care services must be furnished by network providers except emergency health services, and the record does not show that the Petitioner's care was provided on an emergency basis. Therefore, the Director concludes that UHC correctly denied coverage for all the care the Petitioner received from out-of-network providers following his September 17, 2015, injury.

The Petitioner says the hospital told him, based on information it got from UHC, that his surgery would be covered with only a 10% coinsurance on his part. But even accepting that the hospital relayed inaccurate information from UHC to the Petitioner, the Director has no authority under the Patient's Right to Independent Review Act to alter terms of an insurance policy because of any misrepresentation. In this review, the Director can only determine if UHC administered benefits according to the terms and conditions of the policy. MCL 550.1911(13)(d).

The Director finds that UHC's denial of coverage for the services rendered by non-network providers was consistent with the terms and conditions of the policy.

V. ORDER

The Director upholds UHC's four final adverse determinations dated February 2, 2016.

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