

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. 154845-001

United Healthcare Insurance Company
Respondent

Issued and entered
this 22nd day of August 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On August 1, 2016, ██████████, authorized representative of ██████████ (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 August 8, 2016.

The Petitioner receives health benefits through a group plan that is underwritten by United Healthcare Insurance Company (UHIC). The Petitioner's benefits are defined in UHIC's *Navigate Plus* certificate of coverage.

The Director notified UHIC of the external review request and asked for the information used to make its final adverse determination. UHIC submitted material on August 2 and 15, 2016.

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 January 14, 2016, the Petitioner had gallbladder surgery. The anesthesia services were provided by Anesthesia Services Associates, PC, a provider group that

does not participate with UHIC. The amount charged for the anesthesia services was \$2,380.00.

UHIC approved \$162.77 for the anesthesia and applied that amount to the Petitioner's unmet deductible. This left the Petitioner responsible for payment of the full \$2,380.00 charge. She was later billed for this amount by Anesthesia Services Associates.

The Petitioner appealed UHIC's processing of her anesthesia services through its internal grievance process. At the conclusion of that process, On June 23, 2016, UHIC issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Did UHIC correctly process the claim for the Petitioner's anesthesia services?

IV. ANALYSIS

Respondent's Argument

UHIC states that the Petitioner was required to meet her non-network deductible before it would issue any payment for services such as the Petitioner's anesthesia. In the case of the anesthesia services, UHIC's eligible expense was \$162.77. According to UHIC, this amount is calculated using a percentage of the Medicare approved amount for that service.

UHIC says its claim processing procedures are found in the *Navigate Plus* policy's Schedule of Benefits. In its final adverse determination, UHIC explained its processing of claims from non-network providers:

The Eligible Expense is the amount we will pay for a service. You will be responsible for any amount billed that is greater than the Eligible Expense when network benefits are applied to services provided by an out-of-network provider (other than Emergency Health Services or services otherwise arranged by us). You must pay the out-of-network provider any difference between the billed amount and the Eligible Expenses.

The Eligible Expenses applied to this claim were based upon the Extended Non-Network Reimbursement program (ENRP). ENRP is a program that can be used to determine Eligible Expenses when an out-of-network provider is processed under your network

benefits. Reimbursement under ENRP is based on a percentage of the Medicare rate.

* * *

Because the claim(s) for this service(s) was processed according to the above plan provision(s), our original determination remains unchanged, and the determination is upheld.

Petitioner's Argument

In her request for external review, the Petitioner wrote:

A hospital opting to use an out-of-network provider on behalf of a patient is not just and at best I should have been notified in advance that this was even a possibility. I pay the premiums for the health insurance every month and feel I do my part to keep my family healthy to help control medical costs for everyone. I understand and follow the guidelines of my medical plan and promptly pay toward my deductible and any coinsurance. Yet after all that I am told that I owe \$2,380 for a choice of providers that I did not make.

Director's Review

The *Navigate Plus* certificate's "Schedule of Benefits" (page 1) includes this provision:

Accessing Benefits

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

You can choose to receive Network Benefits or Non-Network Benefits.

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

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.

Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, 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 facility based Physician and the amount we determine to be an Eligible Expense for reimbursement.** The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.

Anesthesia services from a non-network provider are a covered benefit subject to the \$4,000.00 deductible. UHIC covered the services, applying its eligible expense of \$162.77 to the Petitioner's unmet non-network deductible. Because the provider was a non-network provider the Petitioner is responsible for any difference between the amount the provider bills and the amount UHIC approves. In this case, the approved amount was applied to the Petitioner's unmet deductible. This claim processing was consistent with the terms of the Petitioner's certificate of coverage.

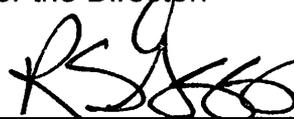
V. ORDER

The Director upholds UHIC's 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