

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 101766-001

v

United HealthCare Insurance Company  
Respondent

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Issued and entered  
this 24<sup>th</sup> day of February 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On December 2, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on December 9, 2008.

The Commissioner notified United HealthCare Insurance Company (United) of the external review and requested the information used in making its adverse determination.

The issue here can be decided by an analysis of the provisions of the Petitioner's health care coverage. The Commissioner 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 has group coverage with United. Her benefits are defined in the United HealthCare Choice Plus certificate of coverage (the certificate) and its applicable riders and amendments.

The Petitioner had outpatient surgery (right hip arthroscopic osteoplasty) performed by XXXXX, DO, on September 3, 2008, at the XXXXX. United processed the claims as non-network benefits.

The Petitioner appealed United's decision. After completing United's internal grievance process, the Petitioner received United's final adverse determination dated November 17, 2008, upholding its decision.

### **III ISSUE**

Was United correct in processing the Petitioner's claims as non-network benefits?

### **IV ANALYSIS**

#### Petitioner's Argument

The Petitioner says that on September 2, 2008, the day before her surgery, she got a telephone call from XXXXX and was told that XXXXX was not in United's network. The Petitioner says she then called United's customer care department to see if this information was correct and was told that both Dr. XXXXX and XXXXX were "covered." Based on this information, the Petitioner says she went ahead with the surgery believing that her providers were in United's network.<sup>1</sup>

#### Respondent's Argument

United said in its final adverse determination:

We carefully reviewed the documentation submitted, our payment policies and the limitations, exclusions and other terms of your Certificate of Coverage, including any applicable Riders, Amendments, and Notices. We confirmed, however, that this service(s) is not eligible for payment as you requested. \* \* \*

According to the Schedule of Benefits section in your Certificate of Coverage, covered healthcare services received from a non-network facility are payable at 60% of eligible expenses after you have satisfied your annual non-network deductible.

We verified that United HealthCare's Customer Care department correctly stated that XXXXX was not a participating provider for your health plan.

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<sup>1</sup> The Petitioner also argued that Dr. XXXXX was the only physician who performs the type of surgery she had. However, that issue was not part of the final adverse determination and therefore cannot be addressed here.

As part of its submission for this external review, United submitted a page from its customer care department call log that indicates the Petitioner called on September 2, 2008, and was told that XXXXX was not a network facility.

United believes that it correctly processed the Petitioner's claims.

Commissioner's Review

The Petitioner's chief argument is that she relied on erroneous information she received over the telephone from United on September 2, 2008, to make her decision to proceed with surgery the next day. United offered call log records to refute that contention. However, even if this kind of dispute could be resolved under the procedures available under the Patient's Right to Review Act, which it cannot, the Commissioner lacks the authority (that the circuit courts possess) to order relief based on such doctrines as promissory estoppel. The Commissioner's role in this case is limited to determining if United correctly processed the Petitioner's claims under the terms and conditions of the certificate.

This table shows the disposition of the Petitioner's claims according to information supplied by United:

A	B	C	D	E	F	G
Provider	Provider's Charge	United's Eligible Amount	Amount Applied to Petitioner's Deductible	United's Payment (60% of C after Deductible)	Petitioner's Coinsurance (40% of C after Deductible)	Ineligible Amount (Petitioner's Responsibility)
XXXXX	\$10,687.68	\$6,748.94	\$885.06	\$3,518.33	\$2,345.55	\$3,938.74
Dr. XXXXX	\$3,500.00	\$3,500.00	-0-	\$2,100.00	\$1,400.00	-0-
<b>Totals</b>	\$14,187.68	\$10,248.94	\$885.06	\$5,618.33	\$3,745.55	\$3,938.74

According to the terms in the certificate's "Schedule of Benefits," non-network physician surgical charges and outpatient facility charges are paid by United at 60% of the eligible amount after the \$1,000.00 non-network deductible has been satisfied. United said that only \$114.94 of the non-network deductible had been met at the time of the Petitioner's surgery; therefore \$885.06 of the eligible amount for the IRMC charge was appropriately applied to the balance of the non-

network deductible. After reviewing the language in the certificate and the table above, the Commissioner concludes that United correctly processed the Petitioner's claims.

It is unfortunate that non-network providers were used for the Petitioner's surgery. As a result, the Petitioner is responsible not only for the deductible and coinsurance but also for any ineligible amount.

The Commissioner finds that United HealthCare correctly applied the provisions of the Petitioner's policy.

**V  
ORDER**

The Commissioner upholds United HealthCare Insurance Company's adverse determination of November 17, 2008. United HealthCare is not required to pay any additional amounts for the Petitioner's outpatient surgery on September 3, 2008.

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 sixty 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.