

**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

v

File No. 102862-001

World Insurance Company  
Respondent

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Issued and entered  
this 20<sup>th</sup> day of March 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On February 6, 2009, 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the information and accepted the request on February 13, 2009.

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

Since this matter does not involve issues of medical necessity or clinical review criteria, it does not require a medical opinion from an independent review organization and can be decided by the Commissioner pursuant to Section 11(7) of PRIRA, MCL 550.1911(7).

**II**  
**FACTUAL BACKGROUND**

The Petitioner has health care coverage from World under an individually underwritten plan. Her benefits are defined in the certificate of coverage (the certificate). The plan includes a

preferred provider network, a selected network of physicians, hospitals, and other health care providers (participating providers) who have agreed to provide services at negotiated prices. The Petitioner generally has less out of pocket expense when using participating providers.

On October 10 and October 17, 2008, the Petitioner had surgeries to remove malignant melanomas on her face. The surgeries were performed by XXXXX, MD, an oncologist in New York City. Dr. XXXXX is not a participating provider.

The Petitioner was not satisfied with World's processing of the claims for Dr. XXXXX's services and appealed through World's internal grievance process. At the conclusion of the grievance process World did not change its decision and issued a final adverse determination dated December 12, 2008.<sup>1</sup> The Petitioner asks the Commissioner to review that determination.

### **III ISSUE**

Did World correctly process the claims for the Petitioner's surgeries?

### **IV ANALYSIS**

#### Petitioner's Position

Because Dr. XXXXX is not a participating provider and therefore had not agreed to accept a negotiated fee for the surgeries, World based its covered amount for his services on the "usual and customary" rate (or fee) for such surgeries. That figure was produced by Ingenix, a company that World uses to establish its usual and customary rates. The Petitioner believes that World's usual and customary rate is too little for Dr. XXXXX's surgery.

The Petitioner referred to a settlement reached between the Attorney General of the State of New York and Ingenix's parent company. The Attorney General had charged that Ingenix was improperly calculating usual and customary rates and the settlement called for Ingenix to participate in the creation of a new, independent database of usual and customary rates.

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<sup>1</sup> Apparently Dr. XXXXX represented the Petitioner in World's internal grievance process because the final adverse determination was addressed to him.

### Respondent's Position

World explained its use of usual and customary rates in its final adverse determination:

Presently, World Insurance Company is licensed to use a pricing guideline module compiled by Ingenix. Almost all health insurance carriers are licensed to use the same or similar systems.

Usual and customary charges are determined by the zip code of the provider in conjunction with the medical procedure and information regarding the charges allowed by participating insurance carriers for the procedure performed by the providers in the area. Once the usual and customary charge is determined by the module, World Insurance processes a claim pursuant to certificate provisions. Set charges are applied to every claim with the same zip code and procedure code. The system is automatically without preference to any particular physician or size of claim. The system is completely impartial and is a standard used in the ordinary course of business within the health insurance industry.

As indicated above, World Insurance used the Ingenix database in order to determine the usual and customary charges for the procedures billed. The amounts determined as usual and customary reflects the 85<sup>th</sup> percentile of charges. Although the usual and customary charges could be considered at the 50<sup>th</sup> percentile, World Insurance uses the higher percentile to offset possible discrepancies.

World believes that it correctly processed the claims for Dr. XXXXX's surgeries.

### Commissioner's Review

The Petitioner understands that using nonparticipating providers can result in higher out-of-pocket expenses. Her fundamental complaint is only that World's usual and customary rates for nonparticipating providers are too low due to calculations performed by Ingenix and she questions the validity of Ingenix's methodology. Presumably she believes that if those rates had been higher she might not have sustained as great an out-of-pocket expense. Unfortunately, that is an issue that cannot be resolved in an external review under PRIRA. PRIRA affords the Commissioner no basis for looking behind World's business practices for setting usual and customary rates. The Commissioner's authority under PRIRA is limited in this case to determining if the terms and conditions of the Petitioner's certificate were correctly applied.

This table shows how Dr. XXXXX's claims were processed:

<b>Date of Service</b>	<b>Dr. XXXXX's Charge</b>	<b>World's U &amp; C Rate</b>	<b>Not Covered</b>	<b>Amount Applied to Deductible</b>	<b>Paid by World</b>	<b>Petitioner's Responsibility</b>
10/10/08	\$3,900.00	\$766.00	\$3,134.00	\$766.00	-0-	\$3,900.00
10/17/08	2,000.00	682.00	1,318.00	682.00	-0-	2,000.00
<b>Totals</b>	\$5,900.00	\$1,448.00	\$4,452.00	\$1,448.00	-0-	\$5,900.00

Because Dr. XXXXX is not a participating provider, World uses its usual and customary rate as the basis for processing the claims for his service. World's usual and customary rate for both surgeries, derived from Ingenix's data, was \$1,448.00. That entire amount was applied to the Petitioner's \$7,500.00 deductible for nonparticipating providers since it had not yet been fully met.

A further consequence of Dr. XXXXX's status as a participating provider is that the Petitioner may also be responsible for the amount not covered, i.e., the difference between Dr. XXXXX's charge and the usual and customary rate. If Dr. XXXXX had been a participating provider he would have accepted World's negotiated fee as payment in full and there would have been no amount not covered.

Based on the record, the Commissioner concludes and finds that World correctly processed the claims for Dr. XXXXX's services according to the terms of the certificate.

## **V ORDER**

The Commissioner upholds World Insurance Company's final adverse determination of December 12, 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.