

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. 103675-001

v

United HealthCare Insurance Company
Respondent

Issued and entered
This 22nd day of July 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 16, 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, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on March 23, 2009.

The Commissioner notified United HealthCare Insurance Company (United) of the external review and requested the information used in making its adverse determination. United provided the information on March 18, 2009.

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.

On September 21, 2008, the Petitioner had a high resolution MRI and related services performed by XXXXX, MD, at the University of Michigan (U of M). U of M and Dr. XXXXX are not part of United's provider network.

United processed the claims as non-network benefits, applying its eligible (or allowed) amount for the services (\$786.77) toward the Petitioner's \$7,000.00 individual out-of-network deductible for 2008. The Petitioner was left responsible for the entire charge of \$3,843.00.

The Petitioner appealed United's decision. After completing United's internal grievance process, the Petitioner received United's corrected final adverse determination dated March 3, 2009, 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 had brain tumor surgery in 1997 and has been followed by the neurology and endocrinology departments at U of M since 1998. She began having seizures in 2006 and eventually her neurologist requested that she have an MRI performed. She says that it was necessary to have the MRI at U of M because of her medical history. According to the Petitioner, U of M has its own MRI special temporal lobe epilepsy protocol and is the only facility that could provide her with the high density MRI she required. In addition, her doctors wanted the MRI performed at U of M so it could be scanned into a database and be accessible for all physicians at U of M.

The Petitioner says she has been seeking treatment at U of M since she developed her

complicated medical condition and it is the only place that specializes in the care she needs. She says, "My case is not a case that can just be transferred to any doctor. I need very specialized care with doctors that are experts in their field."

Based on all these reasons, the Petitioner says she went ahead with the MRI at U of M. She believes the MRI claim should be paid at the network level because the service could only be performed by a non-network provider.

The Petitioner also wants United to verify the accuracy of the codes used to bill the MRI. She notes a discrepancy between the amount billed by the providers and the amount that United has allowed for the MRI.

Respondent's Argument

In its final adverse determination United said:

According to the Schedule of Benefits Section in your Certificate of Coverage, non-network physician fees for surgical and medical services are covered at 60% of the eligible expenses after your non-network deductible has been met.

According to the Schedule of Benefits section in your Certificate of Coverage:

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

United notes that there was no authorization on record for services from a non-network provider and therefore the MRI claim was processed at the non-network benefit level.

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

Provider	Amount Charged	United's Allowed Amount	Not Covered by United	Amount Applied to Deductible
Radiology	\$ 3,206.00	\$ 595.07	\$ 2,610.93	\$ 595.07

Provider	Amount Charged	United's Allowed Amount	Not Covered by United	Amount Applied to Deductible
Misc. Services	140.00	70.00	70.00	70.00
Dr. Wesolowski	497.00	121.70	361.95	121.70
Totals	\$ 3,843.00	\$ 786.77	\$ 3,042.88	\$ 786.77

United applied its allowed or eligible amount for the MRI services (\$786.77) to the Petitioner's non-network deductible. United also noted that since non-network providers do not have contracted rates with United that the Petitioner is also responsible for any amount billed that exceeds United's allowed amount for a service ("Not Covered by United" amount in the table above). Regarding its allowed or eligible amount for the non-network MRI, United quotes from the certificate's Schedule of Benefits:

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on the lesser of:
 - Fee(s) that are negotiated with the provider.
 - 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service.
 - 50% of the billed charge.
 - A fee schedule that we develop.

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

Commissioner's Review

There is no dispute that the Petitioner's MRI and related physician fee were covered benefits under her health care coverage with United. The only question is whether the claims for those services should be processed as network or non-network benefits under the terms of the certificate.

The MRI was performed by non-network providers. According to the certificate's "Schedule of Benefits," non-network physician charges and outpatient radiology services are paid at 60% of the allowed or eligible amount after the \$7,000.00 non-network deductible has been satisfied. United says that the non-network deductible had not been satisfied at the time of the Petitioner's MRI so United applied the entire \$786.77 eligible amount to the non-network deductible. Because the Petitioner received treatment from a non-network provider, she is also responsible for any amounts not covered, i.e., the difference between United's eligible amount and the provider's charge. After reviewing the language in the certificate and the table above, the Commissioner concludes that United correctly processed the Petitioner's claims.

The Petitioner's chief argument is that her MRI should be covered at the in-network level because the services were not available within the network. The certificate permits certain services to be covered at the network level when they are not available from network providers, and the Petitioner has given reasons why she thought the MRI should be performed only at U of M. However, the certificate's Schedule of Benefits first requires that United be notified by a network physician and be given a chance to confirm that the services are not available from a network provider. There is nothing in this record from which the Commissioner could conclude that United was in fact notified. It appears that the Petitioner decided to proceed with the MRI at U of M on the advice of her physicians there without giving United the opportunity to coordinate care.

The Petitioner also questions United's determination of an allowed amount for a non-network MRI and questions whether the service was coded properly. Presumably she believes that if coded differently, the allowed amount would have been higher and 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 the Patient's Right to Independent Review Act (PRIRA). PRIRA does not afford the Commissioner a basis for looking behind United's business practices for setting eligible or allowed rates for services. The Commissioner's authority under PRIRA is limited in this case to determining if the terms of the Petitioner's health care coverage were followed.

The Commissioner concludes and finds that United correctly processed the Petitioner's MRI claims under the terms and conditions of the certificate.

V
ORDER

The Commissioner upholds United HealthCare Insurance Company's adverse determination of March 3, 2009. United is not required to cover the Petitioner's MRI and related services on September 21, 2008, at the network level.

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.