

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

Aetna Life Insurance Company
Respondent

File No. 113270-001

Issued and entered
this 9th day of February 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 7, 2010, 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 Office of Financial and Insurance Regulation notified Aetna Life Insurance Company (Aetna) of the external review and requested the information used in making its adverse determination. Aetna provided the information on July 14, 2010, and Petitioner's appeal was accepted on July 15, 2010.

The Petitioner is covered under a group health plan through her husband's employer, XXXXX Inc., a Michigan-based business. The health plan is underwritten by Aetna Life Insurance Company.

The issue here can be decided by applying the terms of the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

The events described in this appeal occurred in Massachusetts. Because the Petitioner's

benefit plan was issued to a Michigan employer, the appeal is properly adjudicated in this agency.

II FACTUAL BACKGROUND

On April 2, 2010, Petitioner delivered a child by caesarian section under monitored anesthesia. The anesthesiologist, Dr. XXXXX of XXXXX, was not a member of Aetna's provider network. The total charge for the anesthesia was \$4,625.00. Aetna's approved fee for that service was \$2,769.83. Aetna paid \$2,302.40 and calculated the Petitioner's copayment to be \$467.43. Petitioner was billed by the anesthesiologist for the balance of \$2,322.60 (an amount that includes the copayment).

The Petitioner appealed Aetna's processing of the anesthesia services. Aetna reviewed the claim through its internal grievance process but upheld its adverse determination. A final adverse determination dated June 24, 2010, was sent to the Petitioner.

III ISSUE

Did Aetna correctly process the April 2, 2010, claim for anesthesia?

IV ANALYSIS

Petitioner's Argument

Petitioner says that her delivery was not originally intended to be a caesarian delivery and anesthesia services were not anticipated. After prolonged labor, anesthesia was administered and the caesarian delivery performed. Petitioner says she was never offered a choice in selecting an anesthesiologist and therefore, does not feel she should pay out of pocket costs at the non-network rate. The Petitioner wants Aetna to provide additional reimbursement so her out-of-pocket expenses will be based on the in-network level.

Respondent's Argument

In its June 24, 2010, final adverse determination, Aetna explained its decision:

When a physician such as Dr. XXXXX provides services for you, Aetna uses the Reasonable and Customary amounts which is calculated for the area

you live in. The services that Dr. XXXXX provided to you were paid at the in

network benefit level but the allowable amount was the Reasonable and Customary.

Unfortunately when a physician is not contracted with Aetna and there are no contracted rates that both the physician and Aetna agree on then Aetna must have a fair amount that can be considered as the allowable amount.

The recognized charge is the amount that is considered the allowable amount. Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of: The provider's usual charge for furnishing it; and The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or For non-facility charges: Aetna uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80 percentile of PHCS data.

Aetna asserts it processed the claim correctly.

Commissioner's Review

There are four terms related to claims processing which are defined in the policy:

Negotiated Charge – the maximum charge a network provider has agreed to make for any service or supply for the purpose of benefits under the plan.

Network Provider – a provider who has contracted to furnish services for a negotiated charge.

Recognized Charge – that portion of a charge which is a covered benefit.

Copayment – the dollar amount or percentage which the insured is required to pay.

According to Aetna, the recognized charge for this claim is \$2,769.83. Aetna calculated Petitioner's copayment as \$467.43 which is 20% of the payment Aetna negotiated with its in-network providers for this service (\$2,337.14). When the copayment is subtracted from the recognized charge, the amount remaining (\$2,302.40) is what Aetna paid to the provider.

The Petitioner argues that, because she had no choice in the selection of an anesthesiologist, her insurer should pay a larger share of the anesthesia charges. The Commissioner is certainly sympathetic to the situation Petitioner found herself in when her maternity services were administered. Petitioner requests that her claim be reprocessed at the "in-network" level. But paying a provider at that level requires the cooperation of the provider who must agree to

accept the payment as payment in full. Dr. XXXXX, the anesthesiologist, has not agreed to that level of payment and Aetna cannot impose its network rates on the doctor. For Aetna to agree to simply pay what the doctor charged would require Aetna to provide Petitioner with coverage that is not provided in the policy and which it does not provide to other insureds. The Commissioner cannot mandate that Aetna provide additional coverage.

The policy (page 10) cautions:

Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna pays under the plan. Deductibles and coinsurance are usually higher when you utilize out-of-network providers, Except for emergency services, Aetna will only pay up to the recognized charge.

In this case, Aetna correctly processed Petitioner's claims, given that the anesthesiologist was not a participating provider. For these reasons, the Commissioner finds that Aetna processed Petitioner's claim for anesthesia in compliance with the terms and conditions of the certificate.

**V
ORDER**

The Commissioner upholds Aetna's adverse determination of June 24, 2010. Aetna is not required to pay more for Petitioner's April 2, 2010, claim for anesthesia.

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.

Ken Ross
Commissioner