

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 118135-001

United Healthcare Insurance Company

Respondent

Issued and entered
this 20th day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On November 17, 2010, XXXXX, authorized representative of 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 case was accepted on November 24, 2010.

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 Healthcare Insurance Company. His benefits are defined in United's *Choice Plus* certificate of coverage (the certificate).

From February 17 to February 22, 2010, the Petitioner was hospitalized at XXXXX in XXXXX where he had back surgery. XXXXX charged \$30,573.17 for Petitioner's care. XXXXX is not in United's network of providers. United processed the Petitioner's claims at the out-of-network benefit level, applying a \$3,000.00 out-of-network deductible and an 80% reimbursement rate. After United's payment, Petitioner was responsible for over \$26,000.00 of the total charges.

The figures below describe the handling of Petitioner's claims as processed by United:

Hospital charges.....	\$30,573.17
Insurer's allowed amount.....	7,866.64
(United's calculation of its maximum payment)	
Deductible paid by insured	
(insured's unmet deductible at time of surgery) 2,371.76	
Insurer's payment	
(80% of allowed amount minus deductible) 4,395.90	
Balance owed by insured to providers	
(provider charges minus insurer's payment) \$26,177.27	

The Petitioner appealed United's handling of the claim. After completing United's internal grievance process, the Petitioner received United's final adverse determination dated August 31, 2010, upholding its decision.

III. ISSUE

Did United correctly process the claim for the Petitioner's February 17-22, 2010 care?

IV. ANALYSIS

Petitioner's Argument

In his July 26, 2010 appeal letter to United, the Petitioner explained why he believed United did not provide sufficient coverage for his surgery:

I was advised by my doctor on January 18, 2010, that my medical condition required surgery. On or about that same date, I went to the [United] website, and noticed that there were no doctors qualified to perform this surgery within 50 miles of my residence. At that point, I immediately called [United] to inform them of this fact. (Each time I called or contacted [United] by phone, I have been told that my call is being recorded). I was told by the representative at [United] that because there were no providers in area where I live, that the doctor and the hospital (which is also out of network) must first obtain preauthorization prior to the services being rendered, and that [United] would then treat them as "in-network" for this procedure. I also was told that there was nothing else I, my doctor, or my hospital needed to do in this regard. In your current letter to me, you now mention "a network gap exception." I was not advised of, nor had any knowledge of a network gap exception when I spoke with [United]. Had I been

made aware that additional approvals, exceptions, etc were needed, I would certainly have obtained them at that time. If it is true that all of my calls were recorded (as stated to me at the time of each call), it should be an easy matter to review the calls to verify the accuracy of the above statements.

To reinforce the accuracy of the statements made above, I have since had another surgery by the same doctor at the same hospital, and I have a letter from [United] telling me that the health care services will be provided at the network level. . . . This letter also states that although my doctor and the hospital are outside my plan's network, you will cover them "because at this time we do not have a physician, facility or other healthcare professional within your network or area to provide these services."

Petitioner argues that he and his surgeon did as they were told by United representatives and contacted United prior to surgery for authorization at the network level.

Respondent's Argument

In its August 31, 2010 final adverse determination United wrote:

Please be advised that a review of our phone records did not verify that you called prior to your services regarding network providers in your area for your scheduled surgery. Our records with our Care Coordination Department do not verify that you or your network provider requested prior network authorization. For a network gap authorization to be considered this must be done prior to receiving your service(s).

* * *

According to your Benefit Plan, section entitled Schedule of Benefits, inpatient hospital service(s) received from a non-network facility are payable at 80% of eligible expenses after you have met your deductible. Your deductible was not met when your claim was processed. . . .

United then cited two provisions in the certificate's schedule of benefits (page 26) which pertain to the use of network and non-network services. The pertinent portions of those provisions are reprinted below:

Designated Facilities and Other Providers

* * *

If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

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.

Commissioner's Review

The Petitioner's certificate has two levels of deductible: \$1,500 for care provided by United network providers and \$3,000 for care provided by non-network providers. Had the claims been processed at the in-network level as Petitioner requests, United would have paid \$6,366.64:

Approved amount	\$7,866.64
Deductible	<u>\$1,500.00</u>
Balance paid by United	\$6,366.64

At the non-network level, the United payment would be \$4,855.64:

Approved amount	\$7,866.64
Deductible	<u>\$3,000.00</u>
Balance paid by United	\$4,855.64

At the time of his surgery, the Petitioner had already paid down a portion of his non-network deductible. His deductible balance at that time was \$2,371.76. After subtracting the deductible balance from United's approved amount, United was anticipated to pay \$4,395.90 (80% of the approved amount after deductible).

In this case, the hospital was a non-network provider. It is possible in some cases to have non-network claims paid according to in-network benefit levels. In order to do so, the certificate of coverage, as quoted above, requires notification by the Petitioner's network physician. The Petitioner did not have his network physician contact United as required, according to an April 7, 2011 letter received from the Petitioner's representative:

XXXXX never went to his primary care physician, Dr. XXXXX about his back pain. Michael stated he knew that he would need to see an Orthopedic Surgeon. XXXXX states that his wife was seeing an Orthopedic Surgeon for her knee so XXXXX asked her surgeon who he would recommend for a back surgeon. His wife's surgeon recommended Dr. XXXXX.

The Petitioner maintains that he searched the United website and looked for a network provider within 50 miles of his home but found none. He says he then contacted UHC and its representative advised him that services would be paid at the network level since there were no network providers available within 50 miles of his home. His surgeon then contacted UHC and was given authorization for the surgery. UHC claims it was never informed that there were no available network providers within 50 miles of his home until after the surgery was performed.

The Commissioner cannot resolve this factual dispute about whether or not UHC misinformed the Petitioner. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether UHC properly administered health care benefits under the terms and conditions of the applicable insurance certificate and relevant state law. Resolution of factual disputes such as the one described by the Petitioner cannot be part of a PRIRA review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

It should be noted that, at most, United would provide \$7,866.64 in coverage for the \$30,573.17 XXXXX Hospital charge. The difference between the hospital's charge and United's payment constitutes an amount United is not obligated to cover even if, as Petitioner requests, United processes his claim on an in-network basis. Unless XXXXX Hospital has a contractual obligation to accept United's payment as payment in full, XXXXX may still attempt to collect the balance from the Petitioner.

V. ORDER

The Commissioner upholds United Healthcare Insurance Company's adverse determination of August 31, 2010. UHC is not required to pay any additional reimbursement toward the Petitioner's February 2010 surgery.

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 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.

R. Kevin Clinton
Commissioner