

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


Petitioner

v

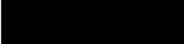
File No. 126570-001

Aetna Life Insurance Company
Respondent

Issued and entered
this 16th day of June 2012
by Randall S. Gregg
Deputy Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 22, 2012,  (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner has health care coverage under an individual policy that is underwritten by Aetna Life Insurance Company. The Commissioner notified Aetna of the external review request and asked for the information it used to make its final adverse determination. Aetna provided its response on March 28, 2012. On March 29, 2012, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue here can be decided by applying the terms of the contract that defines 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.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are contained in a "comprehensive medical expense policy" issued by Aetna (the policy).

The Petitioner had a deviated septum which required surgical correction. The surgery was performed on October 12, 2011, by [REDACTED], MD. Dr. [REDACTED] is not a preferred provider in Aetna's network. He charged \$10,500.00 for the surgery and related services and the Petitioner sought reimbursement from Aetna.

Initially Aetna determined that its "recognized charge" for the surgical procedure (septoplasty, CPT code 30520) was \$577.14 and it applied that amount to the Petitioner's \$1,000.00 out-of-network deductible. It denied coverage for the anesthesia and medical supplies, saying they were incidental to the surgical procedure.

The Petitioner appealed Aetna's payment amount through its internal grievance process. During that process, Aetna decided that its recognized charge for the surgery would be \$1,750.00. It applied \$1,000.00 of that amount to the Petitioner's out-of-network deductible and then paid its 50% of the balance of \$750.00 (\$375.00) to the Petitioner.¹ Aetna continued to deny coverage for the anesthesia and medical supplies, saying they should have been included as part of the primary surgery. Aetna issued a final adverse determination reflecting this decision dated January 30, 2012.

III. ISSUE

Did Aetna correctly process the Petitioner's septoplasty claim under the terms of the policy?

IV. ANALYSIS

Petitioner's Argument

The Petitioner says that she contacted Aetna twice before the surgery and was told that the procedure would be covered at a 50% rate after a \$1,000.00 deductible. In a letter included with her request for external review, the Petitioner wrote:

In May of 2011 I spoke with [an Aetna representative] about this procedure in advance. I gave him procedure codes and amounts. I also gave him my physician's information. He looked up my physician thoroughly.... He then informed me, based on my physician's status, that minus my \$1,000 deductible

¹ Aetna also paid the Petitioner an additional \$3.07 in interest for late payment of the claim.

my procedures, based on the amounts, codes and my physician, my procedure would be covered by 50%. ... I had my surgery scheduled for October and [in August] once again called Aetna to reconfirm my codes and amounts, and based on my physician the amounts that would be covered. I spoke with [another Aetna representative], she looked up my physician and my codes and amounts and told me AGAIN, that minus the out of network \$1,000 deductible, based on the amounts and codes and my physician that I gave her, my procedures would be covered at 50%.

The Petitioner says that she specifically provided all of the procedure codes related to her surgery during her conversations with Aetna's representatives. She understood that Aetna's coverage would be at 50% because Dr. [REDACTED] is not in Aetna's network of preferred providers. Because two customer service representatives told her the procedure would be covered at 50% (after the \$1,000.00 deductible) she believes Aetna is obligated to provide coverage at that level.

Respondent's Argument

In its final adverse determination, Aetna agreed to pay for the Petitioner's surgery at 50% after the \$1,000.00 deductible had been satisfied. However, it based its reimbursement rate on its "recognized charge" for surgery from a non-preferred provider, not on Dr. [REDACTED]'s charge. Aetna continued to deny coverage separately for the anesthesia and the medical supplies:

[W]e are upholding the previous decision to deny reimbursement of for the anesthesia charges and supply charges.

* * *

As for anesthesia code 00160, we will maintain the denial as incidental to the septoplasty charge, based on administration fees for sedation or anesthesia when rendered by the surgeon are considered to be included in the primary procedure as part of the global fee allowance and are, therefore, considered incidental to the charge for the primary procedure.

For supplies code A4649, based on supplies, materials...and equipment...used in conjunction with a medical and/or surgical procedure are considered incidental to the primary procedure. No additional payment will be made for these items.

Aetna asserts that the Petitioner's claim was correctly processed based on the fact that Dr. [REDACTED] is not a preferred care provider.

Commissioner's Review

The Petitioner's health care plan covers services from non-preferred care providers like Dr. [REDACTED]. However, those services are subject to higher deductibles and coinsurance.

Moreover, since they have not agreed to accept Aetna's negotiated rate for services, non-preferred care providers may bill the patient for any amounts not paid by Aetna.

Aetna pays its preferred care providers the rates that it has contracted to pay them for covered services. A non-preferred care provider has not contracted to accept Aetna's rates. Aetna therefore pays non-preferred care providers a "recognized charge." The policy (p. 42) says that "Only that part of a charge for Non-Preferred Care which is recognized is covered." The policy explains how the recognized charge is established:

As to facility charges, the recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it;
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge established in Aetna's Allowable Fee Schedule.

As to other charges, the recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it;
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the negotiated charge that would apply if such services or supplies were received from a Preferred Care Provider.

In the Petitioner's case, Aetna's recognized charge for the surgery was \$1,750.00. Aetna applied \$1,000.00 of the recognized charge to the Petitioner's non-network deductible and then paid the Petitioner 50% of the balance as required by the policy. The Commissioner concludes that Aetna correctly processed the Petitioner's claim for surgery under the terms of the policy.

There is nothing in the policy that requires Aetna to base its payment for a service from a non-preferred provider on anything other than its recognized charge. Furthermore, a non-preferred care provider may bill separately for such things as anesthesia and medical supplies that a preferred care provider would have to include as part of the primary service (in this case, the surgery).

The Petitioner says she got assurances from Aetna that her surgery would be covered fully at 50% after the deductible; she presumed that would include the anesthesia and the medical supplies. However, since Aetna's preferred care providers would have included those charges as part of the primary service (the surgery), Aetna is not obligated to cover them from a non-preferred care provider.

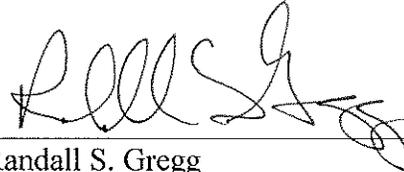
V. ORDER

The Commissioner upholds Aetna's final adverse determination of January 30, 2012. Aetna is not required to reimburse the Petitioner for any additional amount for her septoplasty and related services.

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 the Office of Financial and Insurance Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner

For the Commissioner:

A handwritten signature in black ink, appearing to read "Randall S. Gregg", is written over a horizontal line.

Randall S. Gregg
Deputy Commissioner