

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████
Petitioner

v

File No. 151633-001

United Healthcare Insurance Company
Respondent

Issued and entered
this 29th day of January 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 8, 2016, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives benefits through a group plan that is underwritten by United Healthcare Insurance Company (UHC). The benefits are described in the *United Healthcare Choice Plus* certificate of coverage and schedule of benefits.

The Director notified UHC of the external review request and asked for the information it used to make its final adverse determination. On January 9, 2016, UHC provided its response. UHC provided additional information on January 14, 2016. After a preliminary review of the material received, the Director accepted the request on January 15, 2016.

This case presents an issue of contractual interpretation. The Director 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

On August 23, 2015, the Petitioner received emergency medical care at ██████████ Hospital. The treating physician was ██████████. ██████████ Hospital is in UHC's

provider network; [REDACTED] is not. [REDACTED] Hospital charged \$1,593.24 for the Petitioner's care. [REDACTED] charged \$1,526.00. UHC approved coverage and processed the claims as described below.

<u>PROVIDER</u>	<u>CHARGE</u>	<u>UHC PAYMENT</u>	<u>COPAY</u>
[REDACTED] Hospital	\$1,593.24	\$1,443.24	\$150.00
[REDACTED]	\$1,526.00	\$665.71	\$00.00

The Petitioner appealed UHC's benefit determination for [REDACTED] services through its internal grievance process. At the conclusion of that process, UHC issued a final adverse determination dated December 28, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did UHC correctly process the claim for the Petitioner's August 23, 2015 emergency services provided by [REDACTED]?

IV. ANALYSIS

Petitioner's Argument

The Petitioner's request for external review contained this statement regarding her appeal:

On 8/23/15 I went to [REDACTED] Emergency Hospital for emergency care. [REDACTED] Hospital is an "in network" UHC facility. UHC only paid a portion of the cost billed, so the doctor has billed me for the balance of \$860.29. I was treated at an "in network" facility so 100% of the cost is for UHC. According to UHC they paid only \$665.71 of the total cost of \$1526.00 per agreement; so I should not be billed.

In her internal grievance to UHC, the Petitioner wrote:

The doctor billed me \$1,526.00. UHC discounted the bill and paid \$665.71. Now the doctor is billing me for the balance of \$860.29. I am requesting a review of the claim. I have no control in an emergency.

Respondent's Argument

In its final adverse determination, UHC explained how it processed the claims:

Per the Schedule of Benefits section of the member's Benefit Plan, covered emergency room services are payable at 100% of eligible expenses after satisfying the \$150.00 per visit copayment.

* * *

Because the claim(s) for this service(s) was processed according to the above plan provision(s), our original determination remains unchanged, and the determination is upheld.

* * *

Recently, [REDACTED], D.O., submitted a bill to us for services provided to you....As you know, [REDACTED], D.O., is a non-network provider under the terms of your plan. As a result, we do not have a contract that controls the amount billed. Your coinsurance could be greater than if you were using a network provider.

After reviewing the amount [REDACTED], D.O., charged for these services, we have found that this provider is charging a higher amount than what is typically charged and accepted. We have provided reimbursement to the provider for this claim in an amount that is based on the Center for Medicare and Medicaid Services rate. We do not expect that the provider will bill you for any amounts other than your in-network copay, coinsurance or deductible and that we intend to take whatever measures are necessary to ensure that they do not hold you responsible for that balance.

In its January 14, 2016 response to the Director, a UHC representative disclosed that [REDACTED] claim was processed at 350 percent of the Medicare allowed amount. The representative also stated that the provider was asked not to “balance bill” the Petitioner. However, the representative also conceded that, since [REDACTED] is a non-network provider, there is nothing to prevent him from doing so.

Director’s Review

The Petitioner believes that, because she was treated in an in-network facility, she should not be billed by [REDACTED] for any part of the treatment he provided.

The *Choice Plus* certificate (page 5) includes the following provision regarding UHC’s reimbursement policies:

Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed.

Because [REDACTED] is a non-network provider, he is not prohibited from billing the Petitioner for that portion of his fee not paid by UHC. This is consistent with the language of the *Choice Plus* certificate quoted above.

In conducting reviews under the Patient’s Right to Independent Review Act, the Director is limited to resolving question of medical necessity and determining whether an insurer’s final

adverse determination is consistent with the terms of the relevant policy or certificate of coverage. See MCL 550.1911(13). Therefore, in conducting this external review the Director can only determine whether the insurer has properly processed the Petitioner's claim for emergency medical treatment. The Director has no authority to regulate the conduct of a health care provider such as [REDACTED].¹

The Director finds that UHC correctly processed the Petitioner's claims for emergency treatment under the terms and conditions of the *Choice Plus* certificate and schedule of benefits.

V. ORDER

The Director upholds United Healthcare Insurance Company's December 28, 2015 final adverse determination. United Healthcare is not required to pay an additional amount for the Petitioner's August 23, 2015 treatment.

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

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director

1. According to its final adverse determination, UHC has requested Dr. Richardson not bill the Petitioner for the balance of his fee. While UHC's efforts on behalf of its insured are laudable, the Director cannot compel the provider to comply with UHC's request.