

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. 147249-001

Aetna Life Insurance Company
Respondent

Issued and entered
this 30th day of April 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 9, 2015, ██████████ (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 health care benefits through a group plan that is underwritten by Aetna Life Insurance Company. The benefits are defined in Aetna's *Open Choice PPO* certificate of coverage. The Director notified Aetna of the external review request and asked for the information used to make its final adverse determination. Aetna furnished its response on April 14, 2015. The Director accepted the request for external review on April 16, 2015.

The issue here can be decided by a contractual analysis. 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 December 16, 2014, the Petitioner had an office visit with a non-network surgeon for a 4th degree laceration in her perineum that she has been having problems with since a vaginal delivery on November 25, 2014. The surgeon charged \$200.00. The Petitioner paid the surgeon and requested reimbursement from Aetna. Aetna determined its recognized charge was \$124.27 (\$75.73 was disallowed as exceeding the recognized charge). Aetna applied \$124.27 to the Petitioner's unmet non-network deductible.

The Petitioner appealed Aetna's decision through its internal appeal process. At the conclusion of that process Aetna issued a final adverse determination on March 5, 2015 affirming its decision. The Petitioner now seeks a review of that determination from the Director.

III. ISSUE

Did Aetna correctly process the claim for the Petitioner's December 16, 2014 medical services?

IV. ANALYSIS

Petitioner's Argument

In her request for external review the Petitioner wrote:

After I gave birth to my daughter on the 25th of November 2014 my 4th degree tear wasn't healing. [REDACTED] tried to restitch it but it ruptured again and she sent me immediately to the specialist [REDACTED]. Since it was an emergency I couldn't wait for an in-network MD and he was the closest specialist I was able to see. Aetna has in its claims that they pay in such an Emergency the doctor like an in-network one but they deny it.

With her external review request, the Petitioner also furnished medical records and a brief statement from her gynecologist that it was medically necessary for the Petitioner to be seen by [REDACTED]. The request for external review also included a letter from [REDACTED] office manager which stated that the Petitioner was referred to [REDACTED] "as an emergency case due to the nature of her condition."

Respondent's Argument

In its final adverse determination, Aetna explained its determination to the Petitioner:

In your correspondence, you state the services were rendered on an emergency basis. You also indicated that [REDACTED] was the only proctologist with a 40 mile radius able to render the services. You have requested the charges be considered on a preferred basis.

The group plan states the following under "**How Your PPO Plan Works**":

Accessing Network Providers and Benefits

- You may select any network provider from the Aetna network provider directory or by logging on to Aetna's website www.aetna.com. You can search Aetna's online directory, DocFind, for names and locations of physicians and other health care providers and facilities. You can change your health care provider at any time.
- If a service you need is covered under the plan but not available from a network provider, please contact Member Services at the toll-free number on your ID card for assistance.

- If a service you need is covered under the plan but not available from a network provider, please contact Member Services at the toll-free number on your ID card for assistance.

The Hearing Panel reviewed all submitted documentation. A review of your claim history shows [REDACTED] claim was submitted as an office visit incurred at the physician's office and not an emergency medical facility. Our files do not indicate that Aetna was contacted to locate a participating provider in your area. Aetna's online provider directory, DocFind shows there are two participating colon and rectal surgeon within 15 miles of your zip code. As such, we must conclude our original decision was appropriate. Please note the charge remain eligible under your plan's nonpreferred benefits and have been applied to your deductible.

Director's Review

The *Open Choice PPO* certificate, on page 9, provides:

This PPO plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This PPO plan is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Your deductibles, copayments, and payment percentage will generally be lower when you use participating network providers and facilities.

You also have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. Deductibles, copayments, and coinsurance are usually higher when you utilize out-of-network providers. 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.

Your out-of-pocket costs may vary between network and out-of-network benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

The *Open Choice PPO* certificate's schedule of benefits (page 7) indicates that "Physician Office Visits-Surgery" with out-of-network providers are covered at 60 percent of Aetna's recognized charge after the insured's annual deductible has been met. An "Out-of-Network Provider" is defined in the certificate as "a health care provider...who has not contracted with Aetna, an affiliate, or a third party vendor, to furnish services or supplies for this plan."

The *Open Choice PPO* certificate defines "recognized charge" as:

The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or

supply is the lesser of:

- What the provider bills or submits for that service or supply; and
 - For professional services and other services or supplies not mentioned below:
- 105% of the Medicare Allowable Rate; for the Geographic Area where the service is furnished...

The Petitioner says her condition was “an emergency” that required immediate treatment such that she “couldn’t wait for an in-network MD” and also noted that [REDACTED] was the only proctologist within a 40 mile radius able to provide the needed services. However, [REDACTED] did not bill for an urgent care or emergency visit but rather for an office visit, identified as procedure code 99203 “post-op visit.”

Aetna says that the Petitioner did not seek treatment at an emergency medical facility; therefore, it was not emergency care as defined in the certificate (page 86). Aetna also states that the Petitioner could have selected a network provider because there are two network colo-rectal surgeons within 15 miles of the Petitioner’s zip code. Since the Petitioner had not met her deductible, Aetna applied 100 percent of its recognized charge of \$124.27 to the non-network deductible.

Based on the information provided by [REDACTED] describing the services he provided on December 16, 2014, the Director finds that Aetna correctly processed the Petitioner’s claim.

V. ORDER

The Director upholds Aetna Life Insurance Company’s March 5, 2015 final adverse determination.

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

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director