

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

In the matter of:

██████████
Petitioner

v

Aetna Life Insurance Company
Respondent

File No. 151975-001

Issued and entered
this 11th day of March 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 19, 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 Director accepted the case for review on February 26, 2016. The review concerns the amount paid for a surgical procedure.

The Petitioner received health care benefits through an individual benefit plan underwritten by Aetna Life Insurance Company (Aetna). The benefits are described in Aetna's *Comprehensive Medical Expense Policy*. The Director 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 February 19, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require the analysis of medical issues by an independent review organization.

II. FACTUAL BACKGROUND

On October 1, 2015, the Petitioner had eye surgery (procedure code 68815) at the ██████████ in East Lansing. The surgery was performed by ██████████. Aetna received two claims from these providers: \$1,425.00 from the ██████████ and \$790.00 from ██████████. Aetna's approved amount for the ██████████ claim

was \$741.44. For [REDACTED] claim, Aetna approved \$684.14. The approved amounts were allocated to the Petitioner's unmet 2015 deductible so the Petitioner was required to pay the approved amounts to the providers directly. In addition, the Petitioner had paid \$416.00 to the anesthesiologist. No claim was filed with Aetna by the anesthesiologist.

Prior to her surgery, the Petitioner had called Aetna and asked for an estimate of her out-of-pocket cost for procedure code 68815. She was told that the estimated amount was \$341.09.

The Petitioner appealed Aetna's claims processing decision through Aetna's internal grievance process. She argued that she should pay no more than \$341.09 based on the estimate provided to her. At the conclusion of the grievance process, on December 12, 2015, Aetna issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Is Aetna required to provide any additional coverage for the Petitioner's October 1, 2015, surgery?

IV. ANALYSIS

Petitioner's Position

In her request for external review, the Petitioner wrote:

As you will see in the appeal letter I submitted to Aetna, a large error was made by the Aetna representative who I spoke with on the phone prior to my procedure. After I provided the procedure code to her and requested an estimate of my out of pocket costs, she indicated that the estimated amount was \$341.09., and failed to mention that more than one claim could be submitted using the same procedure code. This estimated amount is a far cry from what the total out of pocket costs for the procedure billed to me were-initially \$1,425.58, but now \$1,217.58. The amount has changed since the time I submitted the appeal because [REDACTED] failed to give me the procedure code for the anesthesiologist for my procedure, so they agreed to decrease the provider bill by half of the cost of the anesthesiology bill (a reduction of \$208). The anesthesiology bill is also included for your reference. I understand that estimates can differ from what a provider and a facility actually bills, but there are two issues: the estimate was nowhere near the actual billed amount, and more importantly, the representative failed to mention that more than one claim could be submitted using the same procedure code, resulting in more than one bill.

I believe it is unacceptable that Aetna was unresponsive to my several requests to reschedule my hearing panel, and am requesting your assistance in working with Aetna to resolve this matter. As stated in my appeal letter, I believe that due to

the misinformation I was given by Aetna over the phone, I should only be responsible for the quoted estimate I was provided: \$341.09. Note: this is in addition to the anesthesiology bill of \$416.00 that I already paid, so the total out of pocket costs I would incur would be \$416.00 more than the estimate). I strongly believe that it is unjust that Aetna can state that information provided over the phone can essentially not be trusted as true information.

Aetna's Position

In its December 12, 2015, final adverse determination Aetna wrote:

This letter is in response to the appeal request we received on November 13, 2015. This appeal is about the following issues:

- The amount applied to your plan deductible for the surgical services rendered by [REDACTED] on October 1, 2015:
 - Total billed charges: \$790.00
- The amount applied to your plan deductible for the surgical services rendered by [REDACTED] on October 1, 2015.
 - Total billed charges: \$1,425.00

* * *

Based on our review of the above information, we are upholding the decision regarding the amount applied to your deductible for the surgical services rendered by [REDACTED] and [REDACTED] on October 1, 2015.

* * *

The hearing Panel reviewed all submitted documentation. A review of your call history shows that you contacted Aetna Member Services and were given a general estimate regarding the plan surgical procedure. There is no indication that specific providers would be reviewed. [sic] The services were rendered at an outpatient surgical center. All providers who rendered services can submit claims for payment.

We regret any misunderstanding of your benefit plan that may have resulted from your conversation with our Member Service area. However, calls to our Member Service area do not constitute a guarantee of coverage. Benefits are determined upon receipt of actual claims for medical services, and claims are subject to all eligibility and coverage criteria specified by the plan. As such, we must conclude our original decision was appropriate.

Director's Review

In conducting reviews under the Patient's Right to Independent Review Act, the Director is limited to resolving questions 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). The Director cannot require an insurer to pay a particular amount for a claim on the basis of "fairness." If the insurer offers a member an estimate of the charges for a medical procedure and the provider subsequently charges more for the procedure, it

is not the insurer's responsibility to pay the difference.

The Director finds that Aetna's claims processing was consistent with the term of the insurance policy.

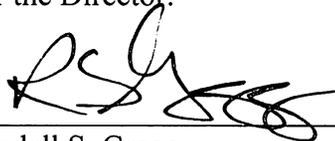
V. ORDER

The Director upholds Aetna's final adverse determination of December 12, 2015. Aetna is not required to provide additional coverage for the Petitioner's October 1, 2015 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 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