

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. 146123-001

All Savers Insurance Company  
Respondent

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Issued and entered  
this 24<sup>th</sup> day of February 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On February 3, 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 coverage through a group plan underwritten by All Savers Insurance Company (All Savers), a subsidiary of United Healthcare. The benefits are defined in the *United Healthcare Choice Plus* certificate of coverage and related riders. The Director notified All Savers of the external review request and asked for the information it used to make its final adverse determination. All Savers submitted the requested information on February 10, 2015 and the Director accepted the case on that date.

This case presents issues 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**

From May 1, 2013 to June 4, 2013, the Petitioner received home care services to treat a surgical wound that would not heal. The care was provided by ██████████. All Savers processed the claims applying its allowed amount to the annual out-of-network deductible which required the Petitioner to pay \$900.00.

The Petitioner appealed the claim determination through All Savers' internal appeals process. At the conclusion of that process, All Savers affirmed its original decision in a final adverse determination dated December 11, 2014. The Petitioner now seeks a review of that determination from the Director.

### III. ISSUE

Did All Savers correctly process the charges for Petitioner's home care services under the terms of the certificate?

### IV. ANALYSIS

#### Respondent's Argument

In its December 11, 2014 final adverse determination, All Savers explained its benefit determination to the Petitioner:

We received your letters dated October 31, 2014, and November 22, 2014, requesting a review of the benefit determination for services rendered from May 1, 2013, through June 4, 2013.

You indicated in your letters you are looking to have your claims processed as in-network. You further indicated you had an email dated June 5, 2014, from [REDACTED] indicating that there is no name listed in the United Healthcare provider file for [REDACTED]. The provider may be billed incorrectly as there is a [REDACTED] listed. The provider would need to send in a corrected claim with the correct provider if that is the case.

A review of your request was completed on December 9, 2014, by a panel of persons not previously involved in the original benefit determination. It is the decision of the reviewing panel that the claims were processed correctly, no additional benefits are available.

\* \* \*

For your consideration, we are providing an explanation supporting our decision. Your plan allows reimbursement at either a Network/Preferred Provider Organization (PPO) benefit level or a Non-Network/Non-PPO benefit level, depending on whether or not the provider is contracted with United Healthcare Choice Plus Network. [REDACTED] was not a contracted provider with United Healthcare Choice Plus Network on May 1, 2013, through June 4, 2013. [REDACTED] is currently a non-participating provider with our network. [REDACTED] and [REDACTED] are participating providers as of January 1, 2014, which is also after the dates of service in question.

We contract with outside vendors to achieve discounts for our insureds when a non-network provider is utilized. One of these vendors is MultiPlan, Inc. [REDACTED]-[REDACTED] has a contract with MultiPlan, Inc., thereby allowing us to receive a discount for services rendered by this provider. This discounted pricing is the covered expense for the services. The difference between the billed amount and the MultiPlan pricing is not billed to the patient by the provider. The charges are normally processed at the non-network benefit level, as [REDACTED]. [REDACTED] is not contracted with United Healthcare Choice Plus network; however, the discounted savings are shared with the insured via a reduction in total charges of the claim.

The eligible expenses under your plan for treatment from [REDACTED] on June 4, 2013 (sub 79), is \$182. The sum of \$182 was applied to your non-network deductible which is your responsibility. The remaining balance of \$18 was a Multiplan discount.

The eligible expenses under your plan for treatment from [REDACTED] on May 1, 2013, through May 28, 2013 (sub 80), is \$728. The sum of \$728 was applied to your non-network deductible which is your responsibility. The remaining balance of \$72 was a Multiplan discount.

We understand and empathize with your situation regarding the processing of your claims under the Multiplan discount versus the United Healthcare Choice Plus Network. Your certificate of health insurance does not contain a provision to process charges as PPO for Non-PPO providers. Therefore, we regret to inform you that additional benefits are not available.

### Petitioner's Argument

In her request for external review, the Petitioner wrote:

According to my records, sources at the hospital and my husband's insurance carrier, [REDACTED] was listed as a provider for my home care service. I was very thorough on this. Claim was said to not be paid as they had filed using [REDACTED]" their old agency name when filed.

The Petitioner provided a detailed explanation of her dispute in an October 31, 2014, appeal letter to All Savers:

I am writing with reference to the above mentioned claims as today I have received an invoice from [REDACTED], which is the first and only statement since service dates during May of 2013 approximately 18 months ago. I had hoped that the service had finally been covered since I had never been billed. On May 19, 2014 I contacted All Savers as I had received the

EOB paperwork reference from above claims of which I was disputing the fact that payment was denied due to the fact that it was an out of network provider.

Not being satisfied with the decision reached on the first contact, I referred my concerns to our employer's agent and through information and ultimately with communications from [REDACTED] in your Claims Department they advised that the provider was to resubmit the claims with the name [REDACTED] [REDACTED] which you DO HAVE LISTED AS IN NETWORK and NOT as [REDACTED] as was apparently submitted originally and to which name is not being recognized as an in network provider.

What is also concerning to me is the fact that in 17 months time from date of service, and again the fact that this was recently addressed in May 2014, I had assumed that [REDACTED] had done as [REDACTED] advised and resubmitted the paperwork under the acceptable name [REDACTED], and yet in all these months since I have received no bill or statement. I do not understand how in the process of billing that no conversation was held between agencies to get to the bottom of the problem of nonpayment which is simply the insertion of the word [REDACTED] within [REDACTED] which is geographically the same address, telephone, etc. I understand that [REDACTED] had recently changed their name which coincided with the time of my surgery, and which may have also added to the confusion. Unfortunately due to this name change, and a type of "technicality" the payment of my claim as IN NETWORK AGENCY has gotten lost in the shuffle....

\* \* \*

I want to use [REDACTED] emailed advice from June 5, 2014, which apparently has not [been] addressed: *"we have received this claim from the provider with the provider name [REDACTED]. In the UHC provider file there is no name listed as [REDACTED]. The provider may be billing incorrectly as there is a [REDACTED] listed. The provider would need to send in a corrected claim with the correct provider if that is the case."*

### Director's Review

The Petitioner's health plan has two levels of benefits: network and non-network. The benefit level for a service is determined by the network status of the provider. According to the certificate's schedule of benefits (page 1), "Non-network benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider."

The schedule of benefits (page 5) further says that the eligible expenses for home health care services from a network provider are paid at 50% after the \$1,500.00 network individual deductible is met. Eligible home health care expenses from a non-network provider are paid at

30% after the \$3,000.00 non-network individual annual deductible has been met. In this case, the petitioner's home health care services were provided by a non-network provider. Accordingly, All Savers' applied the entire eligible home health care expense toward the Petitioner's non-network annual deductible, which had not been met at the time the home health services were performed.

According to the insurer's records, [REDACTED] was not a part of the United Healthcare Choice Plus Network at the time the Petitioner received medical care from them. [REDACTED] remains a nonparticipant in that network. [REDACTED] became a participating provider on January 1, 2014, which is after the time the Petitioner received her treatment.

Based on the foregoing, the Director concludes and finds that All Savers' processing of the home health care claims at the non-network benefit level was consistent with the terms of the certificate of coverage.

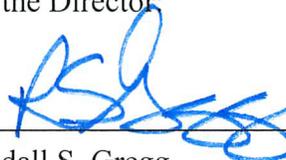
#### V. ORDER

The Director upholds All Savers' December 11, 2014 final adverse determination. All Savers is not required to reprocess the home health care claims as a network-level benefit.

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:



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Randall S. Gregg  
Special Deputy Director