

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. 150743-001

Assurity Life Insurance Company,

Respondent.

Issued and entered
this 2nd day of December 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) received services from an out-of-network provider. His health plan, Assurity Life Insurance Company (Assurity), applied its entire allowable expense for those services to the Petitioner's out-of-network deductible, leaving him responsible for the entire charge.

On November 5, 2015, the Petitioner, dissatisfied with Assurity's processing of the claim, 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 has group health care coverage through a plan that is underwritten by Assurity. The Director immediately notified Assurity of the external review request and asked for the information it used to make its final adverse determination. Assurity furnished its response on November 6, 2015. On November 13, 2015, after a preliminary review of the material submitted, the Director accepted the request.

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

The Petitioner's benefits are described in a certificate of group insurance (the certificate).

The Petitioner was diagnosed with adenoid cystic carcinoma in upper left area of his mouth. In July 2015, following a surgical resection, he received services from a prosthodontist. The services were performed at the [REDACTED] Health System but the prosthodontist was not in Assurity's network.

The charge for the services was \$6,847.00. Assurity's allowable expense for this care was \$4,139.91 and it applied that entire amount to the Petitioner's out-of-network deductible. This left the Petitioner responsible for the total charge of \$6,847.00 (\$4,139.91 applied to the deductible plus the difference between the provider's charge and Assurity's allowable expense or \$2,707.09).

The Petitioner appealed Assurity's claims decisions through its internal grievance process. At the conclusion of that process, Assurity affirmed its determination in an amended final adverse determination dated November 2, 2015. The Petitioner now seeks a review of that determination from the Director.

III. ISSUE

Did Assurity correctly process the claims for Petitioner's July 15, 2015 dental services from [REDACTED] [REDACTED]?

IV. ANALYSIS

Petitioner's Argument

The Petitioner wants Assurity to cover his prosthodontic treatment as an in-network service because he believed that the prosthodontist was part of the [REDACTED] Health System and further because he had no choice in selecting a prosthodontist.

In a letter dated October 30, 2015, included with the external review request, the Petitioner said:

I am writing this brief with regards to [the denial of] my request to consider treatment from [the prosthodontist] at the [REDACTED] of Oral Dentistry as in Network.

* * *

A Biopsy was performed in 6/25/15 with a positive result for Adenoid Cystic Carcinoma I was scheduled to see [my ear, nose, and throat specialist] and [the prosthodontist] on 7/2/15 to discuss my options.

At my visit on 7/2/15 [my ear, nose, and throat specialist] explained the procedure and the need for [the prosthodontist's] services after the resection of the cancer. This is when I asked if they accepted my insurance, Cofinity and they said yes. At this point I did not think I would need to ask [the prosthodontist's] office because they belonged to the [REDACTED] health system. Surgery was scheduled for 7/15/15 at 7:30 am.

The entire upper inside left of my mouth was removed due to this cancer. In order to be able to eat, drink, and speak, I needed the services of [the prosthodontist] to fabricate an obturator to fill in the massive defect that I was left with from this surgery.

It was after the fact that I found out when I received my first bill from the dental office that they accepted Cofinity insurance but did not participate. . . . [The prosthodontist] is the only Prosthodontist (and the only person who has the trained skills to fabricate obturators) with practicing privileges at [REDACTED] Hospital.

* * *

My argument is as follows, I DID NOT have a CHOICE as far as Prosthodontists who were skilled in the manufacturing and with the necessary credentials necessary for my situation. I understand that if there were another Prosthodontist that accepted my insurance, had privileges, and had the necessary training then I would have needed to make a choice. There was not, therefore I could not chose. I will again state that I needed his services because I could not talk understandably, nor would I be able to eat or drink without fear of either entering my lungs. In short I needed my obturator in order to live. . . .

* * *

I am asking the following:

To have all past charges from [the prosthodontist] be listed as In Network while I am covered under my insurance plan . . . and to have all previous charges (out of network deductible and coinsurance) that I have paid to his office, reimbursed to me. . . .

I do not see where this is an unacceptable remedy. After all, I DID NOT have a choice to use his services, it was a matter of sustaining my life.

Respondent's Argument

In its final adverse determination to the Petitioner, Assurity wrote:

[The prosthodontist] is not a participating provider within your selected (Cofinity) PPO. The . . . billing submitted was processed correctly and is an Out of Net-Work Allowed expense under the plan, subject first to the Out of Network deductible (\$5000) and then considered for reimbursement at 80% of the Allowed Expense.

. . . [The prosthodontist] is part of [a practice group] with a provider ID number and billing code separate and distinct from The [REDACTED] Medical Center (participating PPO provider). [The practice group] is a regular, practicing, dental office and is not a participating provider in the selected PPO (Preferred Provider) Health Network. [It] is an Out of Network Dental Provider. The expenses from [the prosthodontist] are clearly Out of Network charges and properly adjusted under the Plan. There are no additional benefits due for these expenses.

Director's Review

There is no dispute that the prosthodontist was not in the PPO network for the Petitioner's plan. According to the certificate's schedule of benefits, outpatient surgery from an out-of-network provider is paid at 70% of the allowable expense after the \$5,000.00 individual out-of-network deductible has been satisfied. Because the out-of-network deductible had not been satisfied at the time the Petitioner received the prosthodontic services, Assurity applied a portion of the allowable expense to that deductible. The Director concludes that Assurity correctly processed the prosthodontist's claims according to the terms and conditions of the certificate.

The Petitioner is displeased with the adequacy of Assurity's network, feeling he did not have a real choice in the selection of a prosthodontist. He is also unhappy with the website of Good Marketing Services, Inc., the entity that manages his employer's health plan for Assurity, saying that it is difficult to locate an in-network prosthodontist. Unfortunately, those issues cannot be resolved in an external review under the Patient's Right to Independent Review Act (PRIRA).

Under PRIRA, the Director can only determine if Assurity correctly processed the prosthodontist's claim under the terms and conditions of the certificate. The Petitioner may have remedies outside of PRIRA for any complaints not resolved in this Order.

V. ORDER

The Director upholds Assurity's November 2, 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 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