

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

In the matter of:

██████████  
Petitioner

v  
United Healthcare Insurance Company  
Respondent

File No. 146242-001

Issued and entered  
this 3<sup>rd</sup> day of March 2015  
by Randall S. Gregg  
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 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 medical benefits through her employer's group health plan underwritten by United Healthcare Insurance Company. The benefits are defined in the *United Healthcare Choice Plus* certificate of coverage. The Director notified United Healthcare of the external review request and asked for the information it used to make its claims decisions. After a preliminary review of the material received, the Director accepted the request on February 17, 2015.

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

In September 2014, the Petitioner had a variety of laboratory tests performed by two laboratories in ██████████ where the Petitioner resides. The tests were ordered by her doctor.

Four tests were performed by ██████████, a non-network provider.

The amount charged for the tests was \$1,028.79. United Healthcare applied an \$848.65 “plan discount” leaving a \$180.14 balance which was applied to the Petitioner’s unmet \$5,000.00 non-network deductible.

On December 23, 2014, [REDACTED] sent a letter to United Healthcare requesting that it reprocess the Petitioner’s claim as an in-network claim because the physician who ordered the tests is in United Healthcare’s provider network. In response to this request, on January 7, 2015, United Healthcare issued a final adverse determination declining change its claim processing.

Also in September 2014, the Petitioner was tested for breast and ovarian cancer using the BRCA-1 and BRCA-2 processes. The tests were performed on September 8 by [REDACTED], a [REDACTED]-based technology company that performs a variety of medical tests. The charge was \$799.00. United Healthcare provided coverage for these tests.

The Petitioner, in her request for external review, described why her doctor prescribed the BRCA tests but she did not claim that United Healthcare had denied coverage for the tests. Additionally, there is no evidence that the Petitioner pursued an internal appeal with United Healthcare with respect to the BRCA tests. In order to be eligible for an external review with the Director of Insurance and Financial Services, an individual must first establish that the internal appeal process has been completed. See MCL 550.1907(2). For these reasons, the [REDACTED] claims are not an appropriate subject for review under the Patient’s Right to Independent Review Act.

### III. ISSUE

Did United Healthcare correctly process the claims for the September 2014 medical tests performed by [REDACTED]?

### IV. ANALYSIS

#### Respondent’s Argument

In its final adverse determination addressing the [REDACTED] claims, United Healthcare wrote to the Petitioner:

We carefully reviewed the documentation submitted, our payment policies and the limitations, exclusions and other terms of your Benefit Plan, including any applicable Riders, Amendments, and Notices. We confirmed, however, that this service(s) is not eligible for payment as you requested. You are responsible for all costs related to this service(s).

According to your Benefit Plan, section entitled Schedule of Benefits:

Your plan states that Lab, X-Ray and Diagnostics - Outpatient services would be covered at 50% of eligible expenses for Non-network provider after satisfying annual deductible.

Your plan's benefits for these services were processed based on the network status of the rendering provider without regard to the facility where the services were performed or the physician who ordered the service.

### Petitioner's Argument

In her request for external review, the Petitioner wrote:

I have a strong family history of breast cancer. My maternal aunt was diagnosed at approximately age 35 (died at 45), maternal grandmother diagnosed, and my mother was diagnosed with breast cancer at age 40. My mother is BCRA [sic] positive which means she carries the cancer gene mutation. Due to my strong family history and the fact that I was having pain in my breast in November 2012, my doctor informed me that I would need to screen for breast cancer every year beginning when I turned 30 years old. And especially since my mother tested positive for BCRA, they felt it was necessary to find out if I had it so we could plan and be prepared if I found out I was BCRA positive. I had my blood drawn and the test was run in September 2014.

The Petitioner did not submit any additional explanation of her dispute with United Healthcare.

### Director's Review

The Petitioner's health care plan covers both network and non-network services. The certificate's Schedule of Benefits provides that benefits are paid based on the network status of the provider and United Healthcare's calculation of "eligible expenses." The Schedule of Benefits, on page 23, provides:

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Certificate.

According to the Schedule of Benefits (pages 11-16), diagnostic laboratory services and

preventive care services are covered at 100 percent of eligible expenses when those services are performed by a network provider. However, when performed by a non-network provider United Healthcare pays 50 percent of eligible expenses after the annual non-network deductible has been met:

If [REDACTED] had been a network provider, United Healthcare would have paid 100 percent of its eligible expenses for the services. But since it is a non-network provider, the services are covered under the non-network provider provisions and cost-sharing requirements. The [REDACTED] claim was calculated by United Healthcare as follows:

Amount billed	\$1,028.79
Plan discount	- <u>848.65</u>
Amount payable	180.14
Deductible required	- <u>180.14</u>
Amount paid by United Healthcare	\$00.00

This benefit calculation is consistent with the terms of the Petitioner's certificate of coverage and Schedule of Benefits.

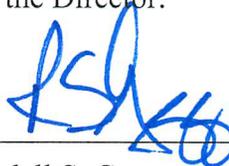
**V. ORDER**

The Director upholds United Healthcare's January 7, 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, P.O. Box 30220, Lansing, MI 48909-7720.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director