

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. 148135-001

UnitedHealthcare Life Insurance Company,
Respondent.

Issued and entered
this 26th day of June 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 1, 2015, ██████████ (Petitioner) filed a complaint with the Department of Insurance and Financial Services regarding a denial of benefits by her health care insurer, UnitedHealthcare Life Insurance Company (UHC).

Because she had already exhausted UHC's internal grievance process, the Director treated the complaint as a request for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*, and, after a preliminary review of the information submitted, accepted the request on June 9, 2015.

During the period when the Petitioner received the services that are in dispute, she had health care coverage through an individual policy that was underwritten by UHC.¹ The Director immediately notified UHC of the external review request and asked for the information it used to make its final adverse determination.

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 review by an independent review organization.

¹ The Petitioner's insurance coverage was obtained through membership in an association (the Federation of American Consumers and Travelers) where the association is the policyholder. Such plans are referred to as association group coverage but in Michigan they are treated as individual, not group, coverage.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits were defined in a certificate of coverage issued by UHC (the certificate) that included the application and riders, amendments, and notices.

From August 14 through October 25, 2014, the Petitioner received occupational therapy from [REDACTED], a non-network provider. The charge for this therapy was \$3,000.00.

When UHC denied coverage, the Petitioner appealed through UHC's internal grievance process. At the conclusion of that process, UHC issued a final adverse determination dated April 1, 2015, affirming its denial. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did UHC correctly deny coverage for the Petitioner's occupational therapy from a non-network provider?

IV. ANALYSIS

Petitioner's Argument

The Petitioner and her children were injured in an automobile accident and all received occupational therapy as a consequence. Her children's therapy claims were paid but hers were not. The Petitioner explained her argument to UHC in an email dated February 26, 2015:

I am asking for an appeal on my treatments with [REDACTED]. I had been given multiple scripts for cranial manual therapy. I had scoliosis and C5/C6 disc bulging/herniation. The treatment was to help with my back and neck to stop shifting and impeding my eyes from coordinating properly. The pain in my upper back and neck was severe. After my children had been approved by [UHC] to work with [REDACTED], the doctor had also written a letter of medical necessity for me. There were six pages of documentation provided. When I called [UHC] I was told it was processing. Then I was told . . . that the documentation had gotten separated from the bills. [I was] told [UHC] was requesting for the treatments to be paid with the letters attached. Then I heard nothing. I faxed [UHC] again. Then heard nothing. When [UHC's representative] called me on my daughter's claim I then asked about mine. She then told me she would put in a request. I still had no response. I called again and was told since I didn't have coverage with [UHC] any longer it was decided to not reconsider to look at the letter of medical necessity with bills attached. My children were approved for treatment. My injuries and pain just as severe but were denied. I had to take care of my children

and drive them for treatments. It was necessary for these treatments so I could get some relief. [REDACTED] was referred to me and I was given no other names of providers. It was also written on the script. I had three scripts from three different doctors for this treatment. Please reconsider these claims for payment.

Respondent's Argument

In its final adverse determination, UHC told the Petitioner its reasons for denying coverage of the occupational therapy:

Your letter suggests your children were approved for treatment; however, your treatment was denied. Your letter indicates you believe the services in question were medically necessary. Therefore, you are requesting the claims be reconsidered for benefits.

A review of your request was completed on March 30, 2015, by a panel of persons not previously involved in the original benefit determination. It is the decision of the reviewing panel to uphold the denial of benefits for the services in question because your plan does not provide coverage for services unless a network provider is used. The claims were processed per the terms and provisions of your plan.

We would like to take this opportunity to explain an exception was made to waive the out-of-network benefits regarding services for [your children]. This exception did not encompass the services provided to you by [REDACTED]

Director's Review

The Petitioner's health plan does not cover services from non-network providers. That restriction is found in several places in the certificate. On the certificate's "Data Page" it says:

Benefits are available only for eligible expenses incurred at a network provider. No benefits are payable for non-emergency or non-urgent care expenses incurred at a non-network provider.

The certificate's "Customer Reference Guide" has this statement:

To receive plan benefits, you must use Network doctors and other healthcare providers. There are no out of network benefits provided with this plan.

And the certificate has this exclusion in Section 7, "General Exclusions and Limitations" (p. 35):

Covered expenses will not include, and no benefits will be paid for any charges which are incurred:

- A. For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by this policy/certificate. . . .

The Director found no exception in the certificate that would require UHC to cover occupational therapy from a non-network provider, even if the therapy was medically necessary.²

The Petitioner had occupational therapy performed and billed by a non-network provider. Therefore, the Director concludes that it was not a covered benefit under the terms of the certificate.

V. ORDER

The Director upholds UnitedHealthcare Life Insurance Company's April 1, 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

² UHC did cover occupational therapy from a non-network provider for the Petitioner's children. However, UHC did not explain its reason for doing so and the certificate does not require UHC to cover that therapy.