

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. 148677-001

UnitedHealthcare Community Plan, Inc.,

Respondent.

Issued and entered
this 3rd day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 6, 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.* After a preliminary review of the material received, the Director accepted the request on July 13, 2014.

The Petitioner has an individual health care plan through UnitedHealthcare Community Plan, Inc. (UHC), a health maintenance organization. The Director notified UHC of the external review request and asked for the information it used to make its final adverse determination. The Director received UHC’s response on July 15, 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

The Petitioner’s health care benefits are described in UHC’s *Silver Compass 250 Individual Medical Policy* (the policy) and its “Schedule of Benefits.”

On March 26, 2015, following a physician office visit, the Petitioner had laboratory services performed by Quest Diagnostics. Quest is not in UHC's provider network. UHC denied coverage for the laboratory services, saying non-network services are not a benefit under the policy. The charge for this service was \$905.83.

The Petitioner appealed UHC's decision through its internal grievance process. At the conclusion of that process, UHC issued a final adverse determination dated June 8, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

In this review, the Director will address only issues that can be resolved under the Patient's Right to Independent Review Act (PRIRA). The Petitioner may have other remedies outside of PRIRA for any complaints that are not dealt with in this Order.

III. ISSUE

Did UHC correctly process the claim for the Petitioner's laboratory services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner's request for external review contained this statement:

I made an app[ointment] to be seen by using the phone number on my insurance card. At the app[ointment] my doctor wanted bloodwork done and now my insurance [doesn't] want to cover their portion of the bill. They say it was out of network but I used the number they gave to me to make my app[ointment].

In an earlier undated appeal letter to UHC, the Petitioner explained her complaint:

I'm writing this letter of appeal because I do not think I should be responsible for my bill. I thought my insurance would cover the cost of my doctor visit but UHC denied it.¹ I don't understand. I called the number that's on my insurance card to make my app[ointment]. A week later I was seen for asthma and the doctor wanted bloodwork done. [Two] weeks later I got a bill in the mail for \$905.xx. I don't understand. Why is that? I used the phone # UHC provided me with, the doctor office accepted my insurance and called UHC while I was there for my app[ointment]. It's really frustrating.

¹ An explanation of benefits statement dated April 9, 2015, says the physician office visit claim was denied because the provider was either not in network or was out of the plan's service area. However, only the laboratory services were addressed in the final adverse determination and are under review here.

Respondent's Argument

In its final adverse determination, UHC explained to the Petitioner its reason for denying coverage for her laboratory services:

[W]e received a request asking for a review of the laboratory service(s) you received on March 26, 2015. We completed the appeal on June 8, 2015.

* * *

Payment was initially denied and the specific denial determination was:

Remark Code: 01 Payment for this service is denied. Benefits are only available when you received services from a provider in your plan's network and in your plan's network service area.

* * *

The claims were processed correctly because the provider is not participating under your plan.

Director's Review

The policy makes clear that, with few exceptions (e.g., emergency health services), care under the Petitioner's plan must be rendered by network providers. The "Schedule of Benefits" says (p. 1):

Accessing Benefits

Compass offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a CompassNetwork provider within the Network Area. You can confirm that your provider is a CompassNetwork provider by calling Customer Care at the telephone number on your ID card or you can access a directory of providers on line at www.myuhc.com.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider within the Network Area.

According to UHC, Quest Diagnostics is not in the network for the Petitioner's plan. Therefore, based on the terms and conditions of the policy and its "Schedule of Benefits," the laboratory services provided by Quest Diagnostics are not a covered benefit because they were rendered by a non-network provider

The Petitioner indicates that she called the telephone number on her UHC card regarding her physician visit but she does not relate what she was told in that conversation. She may have been misinformed by UHC, as she implies, but that is not established in the record. In any event, in a review under the Patient's Right to Independent Review Act, the Director does not have the authority to alter the term of coverage based on an allegation of misinformation.

The Director concludes that UHC's denial was correct.

V. ORDER

The Director upholds UnitedHealthcare Community Plan, Inc.'s June 8, 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