

**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. 149987-001**

**United HealthCare Community Plan, Inc.**  
**Respondent**

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**Issued and entered**  
**this 15<sup>th</sup> day of October 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On September 21, 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's request concerns medical services she received at ██████████ Hospital on June 9, 2015.

The Petitioner receives health care coverage through an individual plan underwritten by United HealthCare Community Plan, Inc. (United). The benefits are defined in United's *Silver Compass 150 Individual Medical Policy*. The Director notified United of the external review request and asked for the information used to make its final adverse determination. United furnished its initial response on September 25, 2015. The Director accepted the Petitioner's request for review on September 28, 2015.

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

On June 9, 2015, the Petitioner underwent a colonoscopy procedure at [REDACTED] Hospital. According to the Explanation of Benefits statements issued by United, the following claims were filed in connection with the procedure:

<u>PROVIDER</u>	<u>SERVICE</u>	<u>AMOUNT CHARGED</u>
[REDACTED] Hospital	Surgery services	\$2,542.66
[REDACTED] Gastroenterology		
[REDACTED]	Surgery	\$613.00
[REDACTED] Outreach	Laboratory services	\$71.00
[REDACTED]	Anesthesia	\$1,016.00
[REDACTED] Gen	Anesthesia	<u>\$480.00</u>
TOTAL		\$4,722.66

United paid the \$480.00 “[REDACTED] Gen” claim and denied coverage for the other claims. The Petitioner appealed the denials through United’s internal appeal process. United affirmed its original decision in two final adverse determinations: one dated August 7, 2015 addressing the \$613.00 claim from [REDACTED] Gastroenterology Associates ([REDACTED]) and one dated August 11, 2015 addressing the \$2,542.66 claim from [REDACTED] Hospital. The Petitioner now seeks a review of those determinations from the Director.

The Petitioner has not submitted a copy of final adverse determinations for the other two claims (for laboratory services and anesthesia). A final adverse determination is proof that the Petitioner has completed the insurer’s internal grievance process which a prerequisite for eligibility for an external review by the Director. Therefore, only those claims with final adverse determinations (the [REDACTED] Gastroenterology Associates claim and the [REDACTED] Hospital claim) are addressed in this order.

## III. ISSUE

Did United correctly process the [REDACTED] Hospital and [REDACTED] Gastroenterology Associates claims for Petitioner’s June 9, 2015 colonoscopy under the terms of the *Silver Compass 150* policy?

#### IV. ANALYSIS

##### Petitioner's Argument

The Petitioner described her complaint in a September 17, 2015 letter that was submitted with her external review request, she wrote:

On 6-09-2015, I had a colonoscopy at [REDACTED] Hospital under the direction of my IN NETWORK physician, [REDACTED].

When [REDACTED] called me to set up the appointment, I gave them all my information on my medical card and asked them if they accepted my Insurance. The response was "absolutely yes."

I at that time had no hesitation to undergo the procedure at [REDACTED]

According to my benefit plan, a colonoscopy should be paid at 100 percent. However, the hospital and physician claims remain denied.

I had filed a request for appeal with United Healthcare for the [REDACTED] claims shown on the attached list and was denied as Out of Network claims. Although United Healthcare recently paid the out of network claims from [REDACTED] Hospital (5-11-2015) as well as one claim from [REDACTED] (6-9-2015 - \$480.00) they continually deny the total \$4,242.66 from the same date, 6-9-2015, all at Botsford....

As a consumer, I have seen advertisements, television announcements, even billboards announcing the merger of [REDACTED] and [REDACTED] Hospitals under the name of [REDACTED]."

After the denials and during my many conversations with United Healthcare, I was told that the ONLY in network hospital available to me is [REDACTED] Doesn't it make sense, then, that I should be considered in network when treating at [REDACTED]

United Healthcare has arbitrarily decided which claims to pay and the most expensive denied.

I pay my premiums in good faith and expect prompt payment of the outstanding bills.

##### Respondent's Argument

In its final adverse determinations, United stated that it had denied coverage because, in each case, the providers were not a part of the provider network for the Petitioner's health plan.

Director's Review

The Petitioner's health plan requires that health care be obtained from network providers in order to be covered. According to the *Silver Compass 150* policy's schedule of benefits (page 1):

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.

The medical services in dispute were rendered by non-network providers. The Director, therefore, finds that United's processing of the June 9, was consistent with the terms of the *Silver Compass 150* policy.

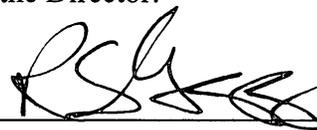
**V. ORDER**

The Director upholds United's August 7, 2015 and August 11, 2015 adverse determinations.

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 Director of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director