

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. 152064-001

United Healthcare Insurance Company
Respondent

Issued and entered
this 27th day of February 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 4, 2016, ██████████, authorized Representative of his wife ██████████ (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 February 11, 2016.

The Petitioner receives benefits through a group plan that is underwritten by United Healthcare Insurance Company (United). The benefits are described in the *United Healthcare Choice Plus* certificate of coverage. The Director notified United of the external review request and asked for the information it used to make its final adverse determination. United submitted material on February 4 and 16, 2016.

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 received care in the emergency department of ██████████ on October 22, 2015. The hospital is a United network provider but the physician that provided Petitioner's care is not a United network provider. The physician charged \$1,629.00. United paid \$665.71 for this care leaving a balance of \$963.29 that was billed to the Petitioner.

The Petitioner appealed the benefit determination through United's internal grievance process. At the conclusion of that process, on January 13, 2016, United issued a final adverse determinations

affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Did United correctly process the claim for the Petitioner's October 2015 physician services?

IV. ANALYSIS

Petitioner's Argument

The Petitioner's request for external review states:

I went to Emergency Care at [REDACTED] on 10/22/15 which is considered in-network according to our plan. We have received a bill for that emergency care for the balance owing of \$963.29. According to our health insurer even though we went to an in-network hospital, the physician, [REDACTED], is considered out-of-network.

I would like either [REDACTED] to accept the payment of \$665.71 as final or UnitedHealthcare to process the charge as in-network. I made the effort to visit an in-network facility, however, I cannot control who they have on staff at any particular time nor was I given any notice that the physician was out-of-network.

Respondent's Argument

In its final adverse determination, United wrote:

Based on our review, according to your Benefits Plan, under the Section Schedule of Benefits, this request for payment was processed correctly.

Your plan states that these services would be covered at 100% of eligible expenses for In-Network provider after satisfying annual deductible.

Your plan states that these services would be covered at 70% of eligible expenses for Non-network provider after satisfying annual deductible.

One of our goals at United Healthcare is to provide you with affordable health care coverage. United Healthcare monitors the amount that physicians, hospitals and other professionals and facilities routinely charge for their services. Recently, [REDACTED] submitted a bill to us for services provided to you on the date of service listed above [October 22, 2015]. As you know [REDACTED] is a non-network provider under the terms of your plan. Your coinsurance could be greater than if you were using a network provider.

After reviewing the amount [REDACTED] charged for these services, we have found that this provider is charging a higher amount than what is typically charged and accepted. We have provided reimbursement to the provider for this claim in an amount that is based on the center for Medicare and Medicaid Services rate. We do not expect that the provider will bill you for any amount other than your network copay, coinsurance or deductible and that we intend to take whatever measures necessary to ensure that they do not hold you responsible for that balance.

You should not be receiving a bill from this provider except for what is required under your United Healthcare plan (e.g. copay, coinsurance or deductible). If you do receive a bill for any additional amount, or have any questions about this letter, please contact our Member Services Department at the number on the back of your member ID card.

Director's Review

United processed the emergency room physician's claim and paid the maximum amount it is required to pay under its schedule of benefits. There is nothing in the certificate of coverage that requires United to pay more than this amount.

The Director notes that United has informed the Petitioner that the physician, despite her non-network status, should not be charging more than the cost sharing provided for under United's benefit plan. United expressed a willingness to intervene on the Petitioner's behalf if the physician billed for any additional amount. Because the Director does not regulate the conduct of health care providers, the Director may not order the physician in this case to refrain from billing the Petitioner. Under the Patient's Right to Independent Review Act, the Director may only review the claims decisions of insurers and HMOs licensed in this state.

The Director finds that the amount that United paid for the October 22, 2015 claim was consistent with the terms of the certificate.

V. ORDER

The Director upholds United Healthcare Insurance Company's January 13, 2016, final adverse determination. United is not required to pay an additional amount for the Petitioner's October 22, 2016 physician care.

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