

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. 152805-001

United Healthcare Community Plan, Inc.
Respondent

Issued and entered
this 13th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 22, 2016, ██████████ (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 has individual health care coverage as a member of United Healthcare Community Plan, Inc. (UHC), a health maintenance organization. The Petitioner's health care benefits are defined in UHC's *Silver Compass HSA 550 Individual Medical Policy*.

The Director notified UHC of the external review request and asked for the information it used to make its final adverse determination. UHC provided its initial response on March 23, 2016, and the Director accepted the case for review on March 29, 2016. UHC provided additional information on April 5, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On July 15, 2015, at ██████████, the Petitioner had a mammogram performed by Huron Valley Radiology. The hospital charged \$310.00. Huron Valley Radiology charged \$75.00. The hospital and Huron Valley Radiology are not in UHC's

provider network. For that reason, UHC denied coverage for the services.

The Petitioner appealed the denials through UHC's internal grievance process. At the conclusion of that process, UHC issued final adverse determinations dated February 22, 2016, affirming its coverage denials. The Petitioner now seeks a review of those final adverse determinations from the Director.

III. ISSUE

Did UHC correctly deny coverage for the Petitioner's July 15, 2015 mammogram?

IV. ANALYSIS

Petitioner's Argument

On her request for external review form, the Petitioner wrote that she seeks payment for a routine annual mammogram and to have her credit rating corrected because she was misled by UHC's employees. In a letter to UHC dated January 17, 2016, submitted with her external review request, the Petitioner wrote:

[W]hen my husband lost his job we lost our health care....

Once we were forced to get health care we decided on UHC. My main concern was mammograms. I was assured that they were covered 100%.

When it was time to make my appointment I had nothing but the run around. I have never experienced representatives that had no knowledge for the company they work for. I called to see what facilities accepted my insurance. I made an appointment, showed up on time [and] found out they don't accept it. I came home called UHC only to find they named the same facility again. We ended up having a 3-way phone conversation. Arguing went on between both parties, guess what, they don't accept UHC.

They gave me the number to another facility. I was on the phone about 15 minutes answering questions. We set up the appointment. I got a phone call the following day telling me they don't accept UHC. The third number they gave me I called constantly [and] was never answered. Talking to a representative again I was told [REDACTED] accepted UHC. I finally got my test on 7-15-2015. Six months later we are still dealing with this.

Months later I received a bill for [REDACTED]. I called UHC to find out its not being covered because it was out of network. This was never mentioned by [UHC's] representative. This makes me very angry. I feel that I was misled and don't plan on paying this bill or any associated to my mammogram....

UHC's Argument

In its final adverse determinations, dated February 22, 2016, UHC wrote:

[B]enefits are only available when you receive services from a provider in your plan's network and in your plan's network service area. The reason was the provider is out of network with your health plan and your health plan does not offer out of network benefits.

* * *

In your health plan documents, Section entitled Schedule of Benefits, Subsection entitled Accessing Benefits, it says:

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

* * *

You mentioned that you were quoted incorrect benefits by a United Healthcare Customer Service Representative; our records do not indicate that you were given incorrect information regarding your medical benefits. Please note that the information given by Customer Care Representatives is not a guarantee of payment, as United Healthcare is responsible for considering the claim as it is submitted and in accordance with the provisions of your plan.

Director's Review

The Petitioner asserts that she was misled by UHC employees when she called to find a participating provider for her mammogram. UHC responds that the Petitioner was not given incorrect information. This kind of factual dispute cannot be resolved through the Patient's Right to Independent Review Act (PRIRA) process which does not make any provision for a hearing where factual disputes can be settled. Under the PRIRA, the Director is limited to determining whether an insurer's decision is consistent with the terms of the applicable policy or certificate of coverage.

UHC's *Silver Compass 150 Individual Medical Policy*, on page 1 of the Schedule of Benefits provides:

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.

A fundamental premise of a health maintenance organization is the centralization of health care delivery within a network of providers. Requirements that a member use providers who are part

of an HMO's network are typical of managed care contracts. HMOs operate within a network of providers who sign contracts to charge specially negotiated rates for services they provide to the HMO's members. The discounted rates are a primary method of cost containment that ultimately benefits every member. If an HMO member uses a non-network provider, payment for those services may be greatly reduced or even excluded entirely, as is the case here.

The Petitioner's mammogram services were obtained from two non-network providers. As a result, UHC is not required to provide coverage for those services. Accordingly, the Director finds that UHC's denial of coverage for the Petitioner's July 15, 2015 mammogram services from [REDACTED] and Huron Valley Radiology is consistent with the term of the Petitioner's insurance policy.

V. ORDER

The Director upholds UHC's denial of coverage for the mammogram charges submitted by [REDACTED] and Huron Valley Radiology.

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