

**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. 150624-001**

**United Healthcare Insurance Company**  
**Respondent**

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Issued and entered  
this 17<sup>th</sup> day of November 2015  
by Joseph A. Garcia  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On October 29, 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 Director accepted the request on November 5, 2014.

The Petitioner receives benefits through a group plan underwritten by United Healthcare Insurance Company (United). The Petitioner's coverage began on January 1, 2015. 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 used to make its final adverse determination. United provided the requested information on November 12, 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 saw ██████████ on January 27, 2015 for a sinus infection. She paid a \$30.00 copayment at that time. In processing the Petitioner's claim, United asserted that ██████████ was not a member of its provider network and, for that reason, the Petitioner would be

responsible for paying the balance of the charge with the payment credited to her annual deductible.

The Petitioner appealed the decision through United's internal grievance process. At the conclusion of that process, United issued a final adverse determination dated September 16, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did United correctly process the claim for the Petitioner's January 27, 2015 services?

### IV. ANALYSIS

#### Respondent's Argument

In its final adverse determination, United wrote:

Your plan states that Out-of-Network services are covered at 70% of eligible expenses after you meet your annual deductible.

Your annual Plan deductible was not met at the time the claim was processed. Therefore, the total allowable expenses were applied to the deductible.

You mentioned getting incorrect information from the United Healthcare website concerning your medical benefits. Our records do not indicate there was incorrect information listed on our website. Please note that the information given on the United Healthcare website is not a guarantee of payment, as United Healthcare is responsible for considering a claim as it is submitted and in accordance with the provisions of your plan.

In your letter you mentioned that you want us to review the recording of your phone call. Unfortunately, not all calls are recorded. The calls that are recorded are only recorded for quality purposes. These calls are typically reviewed for quality and then discarded because of the privacy requirements of HIPAA (Health Insurance Portability and Accountability Act). Our autodocumentation system creates typed records of calls for verification purposes.

#### Petitioner's Argument

In her request for external review the Petitioner wrote:

I confirmed with United Healthcare that [REDACTED] was an in Network/Tier 1 provider both by phone and via UHC's website. I also phoned the

doctor's office and confirmed they were still accepting UHC insurance. I went in and saw the doctor on 1/27/2015. In March I got an email saying a claim had been posted to my account. It showed my appointment with [REDACTED] as Out-of-Network. I called UHC and was told he was in Network and he didn't understand what was going on, put me on hold came back and said there were some credentialing issues. I have gone back and forth with the Doctor's office and UHC for several months and gotten nowhere.

I feel since UHC told me he was a provider, they should honor what they stated. I did my due diligence in checking with multiple sources confirming he was a provider.

The Petitioner also submitted a more detailed letter describing the claim processing by United.

#### Director's Review

The *Choice Plus* certificate of coverage, on page 17, provides coverage for "services provided in a physician's office for the diagnosis and treatment of a sickness or injury." The certificate's schedule of benefits, on page 19, states that these physician services, if provided by an in-network physician, require a member to pay a \$30.00 copayment with United then paying 100 percent of the remaining eligible expense. Physician office services from an out-of-network provider are covered at 70 percent.

The Petitioner says a United representative, in a telephone call prior to her appointment, told her that [REDACTED] was an in-network doctor. The Petitioner states that she also confirmed that fact through the United member website.

In support of its claim that [REDACTED] was not a network provider, United, in its final adverse determination, stated merely, "our records do not indicate there was incorrect information listed on our web site." United did not specify what records were reviewed and how those records supported its position regarding the network status of [REDACTED]. The Director notes that at the present time [REDACTED] is listed as a network provider for the Petitioner's benefit plan.

United acknowledged to the Petitioner that there were unspecified "credentialing issues" with [REDACTED] network status. However, United chose not to address this issue when raised by the Petitioner in her appeal.

The Petitioner also requested that her telephone call to United be reviewed. United responded that not all calls are recorded but did not state whether the Petitioner's call had been recorded or transcribed.

United's account is lacking in detail, conclusory, and, with respect to the telephone call, evasive. United's account is incomplete and inadequate. In contrast, the Petitioner has provided a coherent and believable account of the events surrounding the processing of her claim.

In order to have a denial of coverage upheld by the Director, an insurer must, at a minimum address the issues raised by its member and must provide to the Director a credible explanation for its decision. United has failed to provide these necessary elements.

The Director finds that [REDACTED] was identified by United as an in-network provider at the time of the Petitioner's appointment and, for that reason, the Petitioner's claim should be processed as an office visit with an in-network provider.

#### V. ORDER

The Director reverses United Healthcare Insurance Company's September 16, 2015, final adverse determination. United shall immediately reprocess the Petitioner's claim as an office visit with an in-network provider. United shall, within seven days of reprocessing the claim, provide the Director proof it has implemented this order.

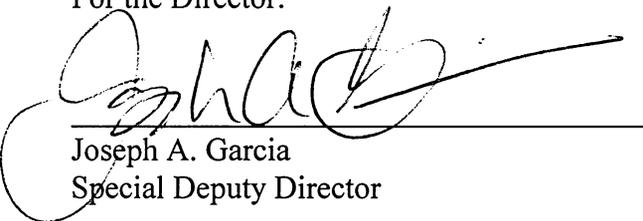
To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 877-999-6442.

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:

  
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Joseph A. Garcia  
Special Deputy Director