

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████,

File No. 150651-001

Petitioner,

v

United Healthcare Community Plan, Inc.,

Respondent.

Issued and entered
this 16th day of November 2015
by Joseph A. Garcia
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) received radiology services from two providers that are not in the network of his health plan, United Healthcare Community Plan, Inc. (United). United denied coverage for those services.

On October 30, 2015, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On November 6, 2015, after a preliminary review of the information submitted, the Director accepted the case for review.

The Petitioner has individual health care coverage through United, a health maintenance organization. The Director immediately notified United of the external review request and asked for the information it used to make its final adverse determination. United provided its response on November 11, 2015.

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

The Petitioner's health care benefits are defined in United's *Platinum Compass 250 Individual Medical Policy* (the policy).

On March 10, 2015, the Petitioner received radiology services from [REDACTED] and [REDACTED]. The charge for the services was \$629.00 (\$31.00 and \$598.00 respectively). United denied coverage because the services were performed by non-network providers.

The Petitioner appealed the denial through United's internal grievance process. At the conclusion of that process, United maintained its denial and issued two final adverse determinations dated September 28, 2015. The Petitioner now seeks a review of those final adverse determinations from the Director.

III. ISSUE

Did United correctly deny coverage for the Petitioner's radiology services?

IV. ANALYSIS

Petitioner's Argument

In a letter dated October 27, 2015, included with the external review request, the Petitioner wrote:

I purchased United Health Care's Platinum plan from the Health Insurance Marketplace in Dec 2014 and it came into effect on 1st Jan 2015. I have a pre-existing condition and I checked if all my doctors/hospitals were within UHC's network before purchasing the plan. As of 1st Jan 2015, most hospitals in my neighborhood and all the doctors that I was consulting were in-network, I checked again in Feb 2015 (before I was admitted in the hospital) using UHC's website and most hospitals especially [REDACTED] was in the network. I even called the billing department at [REDACTED] to check if I'll be covered if I visited their ER and was told their hospital was UHC's in-network hospital.

On 10th March 2015, I underwent a Colonoscopy. . . . My GI [*gastrointestinal*] doctor wanted me to undergo some blood work and x-rays. My Colitis symptoms were so bad that I couldn't go to a hospital as an outpatient for these tests. So, he sent me in a wheelchair to [REDACTED] hospital which was in the same building to undergo the X-ray tests (I had pain in the pelvic area). I was very weak after the Colonoscopy and was still recovering from the anesthesia when I went for the X-ray at [REDACTED]. Since I had checked the coverage of all hospitals in the neighborhood at the time of enrollment in the insurance policy and in Feb 2015, I didn't verify the coverage again. However, I was shocked to receive a bill for \$598 stating [REDACTED] was out of network. Later on, I was told that most hospitals in the region (except William Beaumont Hospital) had opted out of United Health Care's Compass plan and become W500 providers. I didn't receive any notification from United Health Care about the change and that's the main reason for this bill. Had I been informed about the change, I would have gone to William Beaumont Hospital for my X-ray. Hence, I request you to . . . approve this claim.

Respondent's Argument

In both its final adverse determinations to the Petitioner, United said:

The additional payment was initially denied and the specific denial determination was:

Payment for this service is denied. Benefits are only available when, you receive services from a provider in your plan's network and in your plan's network service area.

* * *

We looked at your appeal, the information, sent, our policies, and your health plan documents to make the decision. In your health plan documents, Section Schedule of Benefits, Subsection Accessing Benefits it says:

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

Covered Health Services must be provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered. If you see a Network Physician without a referral from your Primary Physician, Benefits will not be paid. You do not need a referral to see an obstetrician/gynecologist or to receive services, through the Mental Health/Substance-Related and Addictive Disorders Designee.

United says the claims were processed correctly because [REDACTED] and [REDACTED] [REDACTED] are not in the network for the Petitioner's specific plan. United also said it could not locate a telephone record where the Petitioner called prior to the date of service to verify the network status of the providers.

Director's Review

Radiology is a covered service under the policy. However, the policy's schedule of benefits says (p. 1):

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.

The Petitioner received radiology services from non-network providers. Therefore, under the terms of the policy, those services are not covered. On that basis the Director upholds with United's final adverse determinations.

The Petitioner says he "checked if all my doctors / hospitals were within UHC's network before purchasing" the policy. United says that it has no record of a telephone call where the Petitioner inquired about the network status of the specific providers prior to the date of service. Further, the policy's schedule of benefits (p. 19) notes that a provider's status may change:

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

The Director concludes that United correctly processed the claims for the radiology services the Petitioner received on March 10, 2015, according to the terms and conditions of the policy.

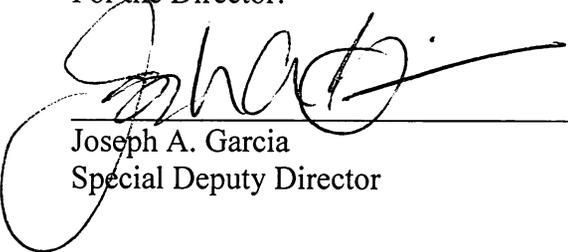
V. ORDER

The Director upholds United Healthcare Community Plan's September 28, 2015, final 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 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:



Joseph A. Garcia
Special Deputy Director