

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. 152758-001

UnitedHealthcare 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 18, 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 receives individual health care benefits through UnitedHealthcare Community Plan (UHC), a health maintenance organization. The Director immediately notified UHC of the external review request and asked for the information it used to make its final adverse determination. The Director received UHC's initial response on March 21, 2016. After a preliminary review of the material submitted, the Director accepted the request on March 25, 2016. The Director received additional documentation from UHC on March 30, 2016.

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

II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in UHC's *Compass Individual Medical Policy* (the policy).

The Petitioner's coverage with UHC was effective on January 1, 2016. On January 11, 2016, she had magnetic resonance imaging (MRI) services from an in-network provider. UHC's eligible expense for the services was \$1,274.80 and, after applying a \$400.00 "per occurrence" deductible and \$262.44 in coinsurance, it paid the provider \$612.36.¹ This left the Petitioner responsible for \$662.44 in out-of-pocket costs.

The Petitioner appealed UHC's claims processing decision through its internal grievance process. At the conclusion of that process, UHC affirmed its decision in a final determination dated March 8, 2016. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did UnitedHealthcare Community Plan, Inc. correctly process the claim for the Petitioner's MRIs?

IV. ANALYSIS

Petitioner's Argument

In a statement submitted with her external review request form, the Petitioner wrote:

January 1, 2016 I began coverage with United Health Care through the Health Exchange. I needed MRI's of the brain and cervical spine which I scheduled in late December 2015 once I had my new insurance plan account numbers, I have not been insured by this organization before. The only information I had available to me about my new plan benefits, which is enclosed, is what was outlined on the Healthcare.gov website description of plan benefits. I was clear about my 30% coinsurance but what was inaccurate and deceptively written was the "Limitations & Exceptions" section where it stated \$400 hospital charge, outpatient surgery. Given that my MRI's were neither scheduled at a "hospital" or was it "outpatient surgery" it seemed clear to proceed with scheduling the MRI's at Beaumont's outpatient satellite center in [REDACTED], which was in the plans network of providers. I had no other information or way of knowing that the plan would consider this "hospital based" nor that there was a different set of providers considered "free standing." The MRI's were done 1/11/16. I received the United Health Care Welcome Kit in late January, after the tests were done. Unfortunately it contained a booklet and detailed description of services covered, exceptions, etc. which would have been useful prior to having the MRI's done. I have appealed UHC's decision to charge me \$400 deductible for obtaining "hospital"

¹ These figures are based on a reprocessing of the claim on March 7, 2016.

services based on their inaccurate description and the limited information I had prior to receiving the detailed plan information. I am now appealing to you to take this under consideration and request that UHC waive the charge under the circumstances.

Respondent's Argument

In its final adverse determination UHC informed the Petitioner:

On February 9, 2016 we received an appeal asking us to reconsider our processing of the above radiology service(s). We completed the appeal on March 8, 2016.

The radiology service(s) being appealed processed with payment being applied to your deductible and coinsurance responsibility for MRI services.

* * *

The Appeals Committee 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, it says, covered - network services for Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient, covered network services rendered at a . . . Hospital-based diagnostic center are covered at 70% of the eligible expense after the per occurrence deductible has been applied and the annual deductible has been met.

Director's Review

The Petitioner wants UHC to waive the \$400.00 per occurrence deductible because she had not received sufficient information from UHC about cost sharing before she had the MRIs. She also states that the "Summary of Benefits and Coverage" that she downloaded says that the per occurrence deductible applies to hospital outpatient surgery, which she did not have.²

In this review under the Patient's Right to Independent Review Act, the Director can only determine if the claim for the MRIs was correctly processed under the terms and conditions of the Petitioner's coverage. The Director must rely on the policy (including its schedule of benefits) to make that determination. The Director cannot alter the terms of the Petitioner's coverage simply because UHC did not immediately send her a detailed explanation of her benefits after she enrolled.

The policy defines "per occurrence deductible" (pp. 67-68):

² The "Summary of Benefits and Coverage" does refer to the per occurrence deductible in the section on the benefit for diagnostic tests.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the Schedule of Benefits for details about the specific Covered Health Service to which the Per Occurrence Deductible applies.

The Petitioner received the MRIs at Beaumont Medical Center in [REDACTED], a hospital-based facility. The policy's "Schedule of Benefits" (p. 8) says the per occurrence deductible applies to outpatient MRIs at a "hospital-based diagnostic center" and says the annual deductible must be met "after the Per Occurrence Deductible of \$400 per service is satisfied." The "Schedule of Benefits" does not limit the per occurrence deductible to surgery.

The Director concludes and finds that UHC correctly processed the claim for the Petitioner's MRIs.

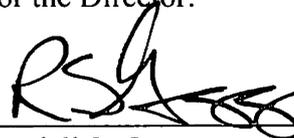
V. ORDER

The Director upholds UHC's final adverse determination of March 8, 2016.

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