

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. 146121-001

Humana Medical Plan of Michigan, Inc.,

Respondent.

Issued and entered
this 23rd day of February 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 3, 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 Petitioner receives health care benefits under an individual plan through Humana Medical Plan of Michigan, Inc. (Humana), a health maintenance organization. The Director notified Humana of the external review request and asked for the information it used to make its final adverse determination. Humana furnished the information on February 4, 2015. On February 10, 2015, after a preliminary review of the information submitted, the Director accepted the external review request.

The issue here can be decided by a contractual analysis. 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's health care benefits are defined in an "Individual Medical Policy" issued by Humana (the policy).

On October 24, 2014, the Petitioner received services from [REDACTED], an out-of-network gynecologist. The charge was \$237.00. Humana denied coverage, saying it does not cover services from non-network providers when there is no prior approved referral from a primary care physician.

The Petitioner appealed Humana's denial through its internal grievance process. At the conclusion of that process Humana maintained its denial in a final adverse determination dated January 26, 2015. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did Humana correctly deny coverage for services from a non-network gynecologist?

IV. ANALYSIS

Petitioner's Argument

In her external review request, the Petitioner said:

After my annual physical my internal medicine Dr. referred me to [REDACTED] [REDACTED] for a Pap smear and annual female checkup. [REDACTED] looked in her computer for GYN's in my network and my doctor said that [REDACTED] [REDACTED]. was indeed in my network. So I scheduled an appt. because my doctor referred her to me with the understanding that she was in my network of doctors.

Respondent's Argument

In its final adverse determination, Humana explained its decision to the Petitioner:

We were unable to approve benefits for the care provided because we find that there are no referrals on file for the services. You have a Health Maintenance Organization (HMO) policy that specifically excludes coverage for services that are received from a non-network provider unless there is an approved referral on file from your Primary Care Physician (PCP). It is ultimately the member's responsibility to verify with Humana that the provider they wish to use is in the network. . . .

. . . Your policy does not require a referral for you to see network obstetrical and gynecological specialists.

Director's Review

Regarding the use of non-network providers, the policy (p. 14) says:

j. Use of non-network providers

Our authorization must be obtained before receiving services from a non-network provider, unless such authorization cannot reasonable be obtained.... Only those services authorized by us to be provided by a non-network provider will be covered expenses.

* * *

It is your responsibility to verify the network participation status of all providers prior to receiving all non-emergency services. You should verify network participation status, only from us, by either calling the telephone number on your ID card or accessing your network detail on our Website. . . . We are not responsible for the accuracy or inaccuracy of network participation representations made by any primary care physician, specialty care physician, hospital, or other provider whether contracted with us or not. In other words, if the network primary care physician, specialty care physician, or other provider recommends that services be received from another entity, it is your responsibility to verify the network participation status of that entity before receiving such services. If you do not, and the entity is not a network provider (regardless of what the referring provider may have told you), you will be responsible for the cost incurred.

The policy also has this exclusion under "General Exclusion" (p. 37):

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

* * *

2. Services provided by a non-network provider, except when:
 - a. Authorized by us;
 - b. A referral is obtained from a primary care physician; or
 - c. A referral is obtained from a primary care physician; or
 - i. Professional ambulance service;
 - ii. Services in a hospital emergency room; or
 - iii. Services in an urgent care center;
3. Services provided by a non-network provider except as expressly provided in this policy;

These provisions make clear that non-network services are generally covered only when they are authorized in advance and that it is the Petitioner's responsibility to verify the network status of the provider and obtain the authorization.

Unfortunately, the Petitioner relied on her doctor to ascertain the network status of [REDACTED]. [REDACTED] Humana has distinct networks associated with the various health plans it offers and apparently [REDACTED] is not in the network associated with the Petitioner's health maintenance organization. The policy (p. 12) has this provision cautioning about the need to verify the network status of a providers:

b. Use of network providers

. . . We offer many managed care plans, and a provider who participates in one plan may not necessarily be a network provider for this policy.

When receiving services from network providers, you should make sure the provider participates as a network provider in this policy's network.

The Director finds that Humana correctly denied coverage for the Petitioner's care from [REDACTED], a non-network provider, because no advance authorization had been obtained.

V. ORDER

The Director upholds Humana's January 26, 2015, final adverse determination.

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 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.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director