

**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. 148039-001**

**Humana Medical Plan of Michigan, Inc.**  
**Respondent**

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**Issued and entered**  
**this 16<sup>th</sup> day of June 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On May 26, 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 benefits through an individual medical policy that is underwritten by Humana Medical Plan of Michigan, Inc. (Humana). 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 requested information on May 27, 2015. After a preliminary review of the material received, the Director accepted the request on June 2, 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**

On February 13 and 20, 2015, the Petitioner had office visits with ██████████, an orthopedic surgeon. Claims for \$298.00 and \$115.00 were submitted to Humana. The claims were denied.

The Petitioner appealed Humana's decision through its internal grievance process. At the conclusion of that process, Humana issued a final adverse determination dated April 23, 2015,

affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did Humana correctly process the claims for the Petitioner's office visits?

### IV. ANALYSIS

#### Respondent's Argument

In its final adverse determination, Humana provided this explanation of its coverage denial:

[W]e're unable to approve services provided by [REDACTED] on February 13, 2015, and February 20, 2015. Please refer to the enclosed Health Benefits Processing Chart for more detail.

#### **Why we were unable to approve your appeal**

The authorization submitted by [REDACTED] was received after your services were rendered by [REDACTED]. Therefore, services were processed correctly according to the terms and provisions of your Benefit Plan Document. It is best practice to verify with Humana the network status of a provider before receiving services.

The policy states, under General Exclusions on page 42, unless specifically stated otherwise, no benefits will be provided for, or on account of, services which require a primary care physician referral if a referral was not obtained. Services provided by a non-network provider, except when authorized by us or a referral is obtained from a primary care physician. [sic]

The "Health Benefits Processing Chart" referred to in the final adverse determination states, "Services are not payable. There is no HMO outpatient authorization on file."

#### Petitioner's Argument

In his appeal letter to Humana dated March 17, 2015, the Petitioner wrote:

On February 4<sup>th</sup> [2015] I had an appointment with [REDACTED] at Eastpointe Internists where I received an Ambulatory referral to Orthopedic Surgery. I have arthritis in my right ankle and I wanted to see if I was a candidate for replacement or fusion as it has become very painful. I logged into the Humana website to find an Orthopedic Surgeon in my area and I found [REDACTED] on the Humana Physician finder page of the website. I scheduled an appointment for the

13th of February to see [REDACTED]. I had x-rays done of my right ankle and [REDACTED] informed me that my ankle is very arthritic. I asked him about replacement and he suggested that I was a better candidate for fusion....I was contacted by the surgery scheduler and was informed that I could have surgery on the 30<sup>th</sup> of March.

\* \* \*

I called Humana on either the 12th or 13th of March and I was told that [REDACTED] was not a doctor that accepted my insurance. I found [REDACTED] by logging into the Humana web site and that's how I chose him as a provider. I was told [by Humana] to get a referral specifically for [REDACTED] from [REDACTED] office. I called [REDACTED] office and informed them that I just spoke to Humana and I was told to get a specific referral for [REDACTED] to cover my x-rays and appointments. I did not hear back from Humana or [REDACTED] office for a couple of days, so I called Humana again on 03/17/15 since my surgery date was getting near. I spoke to Alyssa Blackburn [who] informed me that [REDACTED] no longer accepted my insurance plan after the 10<sup>th</sup> of March 2015. I had made the appointment a day or two after I received the referral from [REDACTED] office and [REDACTED] was still in the Look up a Provider/Physician section of Humana's website.

### Director's Review

The Petitioner's policy provides benefits for medically necessary services received from network providers. The requirements for treatment by a specialist or non-network provider are stated in Section 3 of the policy, which includes these provisions:

#### **3. ACCESS TO CARE**

\* \* \*

##### **d. Role of the primary care physician**

*A covered person's primary care physician is responsible for providing primary medical care and helping to guide any care they receive from other medical care providers, including specialty care physicians. Referrals to specialty care physicians are required by us.*

\* \* \*

##### **f. Seeing a specialist**

*All medical needs should be discussed with the primary care physician. If a covered person and their primary care physician determine that there is a need to see a specialty care physician, the primary care physician will recommend one. Services received from a specialty care physician without the required primary care physician referral will not be considered covered expenses.*

\* \* \*

**j. Use of non-network providers**

*Our authorization must be obtained before receiving services from a non-network provider, unless such authorization cannot reasonably be obtained. In the event that network providers are unable to provide covered services, or a covered person feels that the services available to treat the condition are not adequate, the covered person and their provider must receive our authorization for non-network services before any service is provided. 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 at [www.humana.com](http://www.humana.com). *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 all costs incurred.

Humana asserts that the Petitioner failed to obtain the necessary prior authorization to see a nonparticipating provider. This assertion is based on the assumption that [REDACTED] was a nonparticipating provider. If he was a participating provider, prior authorization would not be required. The certificate provisions quoted above direct Humana members to consult the Humana website to determine a provider's participation status. The Petitioner did this a few days before his appointments with [REDACTED]. The Petitioner found [REDACTED] on Humana's website shortly after his February 4 appointment with his primary care doctor who referred him to an orthopedic surgeon. At that time, [REDACTED] was listed as a Humana participating doctor.

According to the Petitioner, Humana informed him during the course of the internal grievance that [REDACTED] was not a participating provider after March 10, 2015. Humana has not disputed this assertion or provided any other information about the length of time [REDACTED] was a participating provider.

In its final adverse determination, Humana stated that its coverage denial was based on the fact that the Petitioner did not obtain an "authorization" from his primary care physician until after the appointments with [REDACTED]. However, under the policy, an authorization is not

required when medical care is obtained from a participating provider and a referral has been made by the primary care doctor.

Because [REDACTED] was a Humana-participating provider at the time of the Petitioner's appointments, and because the Petitioner's primary care physician referred him to an orthopedic surgeon, the Director finds that the appointments were covered under the Petitioner's benefit plan.

#### V. ORDER

The Director reverses Humana's April 23, 2015, final adverse determination. Humana shall immediately provide coverage for Petitioner's February 13 and 20, 2015 appointments with [REDACTED]. See MCL 550.1911(17). Humana shall, within seven days of providing coverage, submit to 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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Randall S. Gregg  
Special Deputy Director