

STATE OF MICHIGAN
DEPARTMENT OF LICENSING & REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 120560-001

v

Humana Insurance Company
Respondent

**Issued and entered
this 8th day of July 2011
by R. Kevin Clinton
Commissioner**

ORDER

I. PROCEDURAL BACKGROUND

On April 12, 2011, XXXXX, on behalf of his minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Humana Insurance Company (Humana) of the external review and requested the information it used to make its adverse determination. The information was provided on April 13, 2011. On April 19, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The issue here can be decided by applying the terms of contract. The contract is the Humana Certificate of Insurance (the certificate), which defines the Petitioner's health care benefits.

The Commissioner 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 December 30, 2010, the Petitioner, then XXXXX years old, fell on his right arm. He was taken to the emergency room (ER) at XXXXX in XXXXX where he was diagnosed with a fracture of the growth plate of his right distal humerus. Due to the severity and complexity of his injury, he was immediately referred to XXXXX in XXXXX for possible surgery and was told to immediately report to the ER at XXXXX. After a consultation with an orthopedic pediatric specialist at XXXXX, surgery was scheduled for January 1, 2011.

The ER visit at each hospital was subject to a \$150.00 copayment. The Petitioner's father contends there should have been only one ER copayment. He appealed the application of the copayment at XXXXX through Humana's internal grievance process. At the conclusion of that process, Humana affirmed its decision in a final adverse determination dated March 2, 2010. The Petitioner now asks the Commissioner to review that adverse determination.

III. ISSUE

Did Humana correctly apply a \$150.00 copayment to ER services at XXXXX?

IV. ANALYSIS

Petitioner's Argument

The Petitioner believes the second ER copayment should be waived because he did not go to XXXXX voluntarily – he was instructed to go to XXXXX to be seen by a pediatric specialist and was told to report to the ER. In his request for this external review, the Petitioner's father wrote:

[I]t is obvious that there is a continuum of care at both hospitals . . . as well as no duplication of services on December 30, 2010. We were following the recommendation of an approved PPO hospital to go to another establishment for the appropriate medical care based on the patient diagnosis. . . . [T]wo co-pays for one continuum of service is not acceptable.

The Petitioner believes the copayment for the second ER visit should be waived.

Respondent's Argument

In its March 2, 2011, final adverse determination, Humana declined to waive the second ER copayment:

. . . After a full and fair review of the information, we are unable to approve an additional payment of the emergency room copayment from XXXXX.

* * *

We were unable to approve the payment of the emergency room copayment because the claim from XXXXX [was] processed correctly according to your plan provisions. On page 21 of [the Petitioner's] plan provisions, an emergency room copayment of \$150.00 is applied per visit. Therefore, the services provided are appropriately reimbursed according to the member's emergency room benefits.

The claim was processed correctly according to the terms and provisions of the plan . . .

Commissioner's Review

Under the terms of the certificate, ER visits are subject to a \$150.00 copayment per visit.

The certificate has this provision in the Schedule of Benefits:

Emergency Services

Hospital emergency room services

<i>Network hospital</i>	100% benefit payable after \$150 copayment per visit. Copayment waived if admitted.
<i>Non-network hospital</i>	100% benefit payable after \$150 copayment per visit. Copayment waived if admitted.

The Petitioner's father states it was not his choice to visit a second hospital ER after the accident - - they were sent to XXXXX because of the severity of the injury and were told to report to the ER. Unfortunately, the Commissioner finds nothing in the certificate or state law that would require Humana to waive an ER copayment because the Petitioner was seen in succession at two

ERs for the same injury on the same day. The \$150.00 copayment is applied for each ER visit. The certificate states the ER copayment is only waived if the patient is admitted to the hospital after coming to the ER; here the Petitioner was not admitted to the hospital.

The Commissioner finds that Humana correctly processed Petitioner's claims under the terms and conditions of the certificate.

V. ORDER

The Commissioner upholds Humana's final adverse determination of March 2, 2011. Humana is not responsible for waiving the second emergency room copayment on December 30, 2010.

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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner