

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

In the matter of:

██████████
Petitioner

File No. 145373-001

v
Humana Medical Plan of Michigan, Inc.
Respondent

Issued and entered
this 28th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 5, 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 individual health care benefits as a member of Humana Medical Plan of Michigan, (Humana) a health maintenance organization. The Director notified Humana of the external review request and asked for the information used to make its final adverse determination. Humana provided its response on January 5, 2015 and the Director accepted the case for review on January 12, 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

Between July 21, 2014 and September 29, 2014, the Petitioner received medical services from four providers ██████████ Hospital, ██████████, ██████████ and ██████████. None of these providers are members of Humana's Detroit HMOx provider network. Humana provided coverage for the Petitioner's September 5, 2014 and September 25-29, 2014 services from ██████████ Hospital, applying a 20 percent coinsurance charge. (Humana has stated that this approval was made in error but their payment has now been

approved on an exception basis). Humana denied coverage for the July 21, 2014 through August 26, 2014 dates of service because the providers are not in Humana's HMOx network and because there was no approved referral on file.

The Petitioner appealed the denial through Humana's internal grievance process. At the conclusion of that process, Humana maintained its denial and issued a final adverse determination on December 3, 2014. The Petitioner now seeks a review of that determination from the Director.

III. ISSUE

Did Humana properly deny network-level coverage for the medical services Petitioner received from non-network providers between July 21, 2014 and August 26, 2014?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination, Humana wrote:

We were unable to approve benefits for the services provided on July 21, 2014; July 29, 2014; July 30, 2014; August 6, 2014; August 12, 2014; August 13, 2014; August 26, 2014; and August 26, 2014 from [REDACTED] Hospital; [REDACTED] [REDACTED] because these providers are not contracted within your policy network ([REDACTED] HMOx). Member's policy excludes benefits for services rendered by a non-network provider for non-emergent care unless an approved referral is on file. Humana has no approved referral on file; therefore, we correctly denied claim numbers 990105241; 994039574; 998470407; 000845907; 004902462; 987249572; 990521045; 993943413; 006418266.

Your letter states that at the time of application you were informed that [REDACTED] [REDACTED] Hospital, [REDACTED] are contracted providers. Please note that these providers are contracted with the Humana/ChoiceCare network and not the [REDACTED] HMOx network. Because you enrolled into your policy with the Marketplace, Humana has no record of you being informed that these providers are contracted with the [REDACTED] HMOx network. Ultimately, it is the member's responsibility to verify that all of their providers are contracted prior to receiving services to ensure the highest level of benefits. Humana has no record of you or your providers calling to verify benefits prior to having services rendered on the dates of service listed above.

Your primary care physician, [REDACTED], listed on your identification card (not [REDACTED] [REDACTED]) must contract [sic] Humana for the referral prior to

having services rendered. Because the primary care physician did not contact Humana to have the referral approved prior to having services rendered the services [were] denied correctly.

In addition, Humana approved network benefits for the services provided on September 5, 2014 and September 25, 2014 through September 29, 2014 from [REDACTED] Hospital. Your total responsibility for these services is \$3,435.97 because Humana applied \$2,562.09 toward your network deductible amount and \$873.88 toward your network coinsurance. Therefore, no additional benefits are available for the services provided on claim numbers 009362328 and 021386842.

Petitioner's Argument

In a letter to Humana dated October 27, 2014, the Petitioner explained the reason for her appeal:

The purpose of this letter is: I was lied to. The following will explain what transpired and what I am requesting.

On December 28, 2012 I took an early retirement at the age of 62. I signed up for health insurance with Blue Cross Blue Shield and thought I was all set until I turn 65, which will be in July. To my surprise, I received a letter dated April 28, 2014 indicating that as of June 28, 2014 I was no longer entitled to this health plan. I contacted the phone number [of an insurance broker], 1-877-437-4344, they supplied for alternative coverage on May 7 2014 and spoke with [REDACTED] [REDACTED] who suggested Humana. In my conversation with [REDACTED] I asked several times if my primary, [REDACTED] [REDACTED] (working out of [REDACTED] [REDACTED] in [REDACTED], [REDACTED]), and [REDACTED] Hospital (in [REDACTED], [REDACTED]) were in the plan and I was assured each and every time they were, so I signed up for Humana. My sister heard me ask several times if they were in the network.

In July I needed to make an appointment with [REDACTED] for a problem I developed. I saw [REDACTED] [REDACTED] for the problem and she discovered I had high blood pressure [for] which medication was prescribed. I went back the following week for her to re-evaluate my condition. On the first visit she had me make an appointment with a GYN, [REDACTED]. He gave me an exam and wanted an ultrasound done and then a CT scan. After his findings, he sent me to [REDACTED] [REDACTED] a GYN oncologist. Findings were I needed a complete hysterectomy. Surgery was scheduled for September 25. On September 22, I received a call from [REDACTED] nurse saying Humana declined the surgery. This is where all the problems started. When I called Humana to see why it was declined, I was told that [REDACTED] was not in the network. Talking to one of Humana's representatives, a waiver was given for me to have the surgery. Another waiver

has been given for radiation treatments I need. These treatments will begin November 5.

I have received a bill from [REDACTED] Hospital which totaled \$4,677.75 of which I am requested to pay \$4,150.09 because of [REDACTED] being out of network. This is just from the doctors visits and tests that were taken. I have not received a bill yet as to how much the hospital stay, the surgery and the anesthesia will be. [REDACTED], as stated above and assured to be in the Network, should be sending the bill to Humana and not to me.

In closing, since I was lied to when I signed up with Humana, I am requesting Humana pay the amount that would be paid if [REDACTED] was in the network.

Director's Review

The Petitioner argues that her claims should be paid because she was not told the truth about the Humana network at the time she purchased her Humana coverage. She states that she was told, falsely, that the [REDACTED] Health System and her primary care physician were members of her Humana provider network. Later, she says, she learned that they were participants in a Humana network that was not available to her under her Humana HMO coverage.

The Petitioner's policy contains these provisions regarding the use of non-network providers and prior authorization requirements:

3. ACCESS TO CARE

* * *

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....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.

[Page 16]

4. UTILIZATION MANAGEMENT

- a. Preauthorization and notification (also referred to as prior authorization)

* * *

Preauthorization by us is required for certain services and prescription drugs. Visit our Website at www.humana.com or call the telephone number on your ID card to obtain a list of services and prescription drugs that require preauthorization and notification. The list of services and prescription drugs that require preauthorization and notification is subject to change....

You are responsible for informing your healthcare practitioner of the preauthorization and notification requirements. You or your healthcare practitioner must contact us by telephone, electronically or in writing to request the appropriate authorization. Your ID card will show the healthcare practitioner the telephone number to call to request authorization....

[Page 18]

6. GENERAL EXCLUSION

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

* * *

1. Services which require a primary care physician referral if a referral was not obtained;
 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
- * * *
3. Services provided by a non-network provider except as expressly provided in this policy...

[Page 39]

These provisions establish the need for prior authorization and the circumstances under which treatment by non-network providers is excluded. The medical care received by the Petitioner is excluded based on those provisions.

The Director notes that the Petitioner's claims do not involve Humana directly. The information she says was false came from an individual not employed by or representing Humana. The person she spoke with regarding her coverage works for an insurance broker in Oregon whose services the Petitioner apparently used to purchase her Humana coverage.

Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether Humana properly administered health care benefits according to the terms and provisions of the applicable insurance policy and any relevant state law. The Director has no authority to amend the terms of a health care policy based on oral statements made by an insurer's employees or other persons.

Humana's claims decisions were correct and consistent with the terms of the Petitioner's policy. The Director has no regulatory control over brokers or other persons the Petitioner may have consulted when she was looking for health insurance.

V. ORDER

The Director upholds Humana's December 3, 2014 final adverse determination. Humana is not required to provide coverage for the non-network medical services the Petitioner received.

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