

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

In the matter of:

██████████,

Petitioner,

v

File Nos. 147712-001 & 147791-001

Humana Medical Plan of Michigan, Inc.,

Respondent.

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Issued and entered  
this 22<sup>nd</sup> day of May 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On May 1 and May 7, 2015, ██████████ (Petitioner) filed requests with the Director of Insurance and Financial Services for external reviews under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the requests on May 8 and May 14, 2015. Both requests will be reviewed in this Order.

At the time the Petitioner received the services in dispute in this review, he had health care coverage under an individual plan from Humana Medical Plan of Michigan, Inc. (Humana), a health maintenance organization.<sup>1</sup> The Director notified Humana of the external review requests and asked for the information it used to make its final adverse determination.

The issues here can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). These matters do not require a medical opinion from an independent review organization.

**II. FACTUAL BACKGROUND**

The Petitioner's health care benefits were defined in an "Individual Medical Policy" issued by Humana (the policy).

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<sup>1</sup> The Petitioner was covered under this plan from May 1 through November 30, 2014. He obtained the coverage through the Health Insurance Marketplace.

On May 8, 2014, the Petitioner received laboratory services at [REDACTED] an out-of-network provider. The charge was \$428.00.

On July 8, 2014, while at [REDACTED] for outpatient care, the Petitioner received anesthesia services from [REDACTED], also an out-of-network provider. The charge for the anesthesia services was \$875.00

Humana denied coverage for both services, saying they were not covered because they were rendered by out-of-network providers without approval in advance from Humana.

The Petitioner appealed both denials through Humana's internal grievance process. At the conclusion of that process Humana maintained its denial in two final adverse determinations dated April 22 and April 27, 2015. The Petitioner now seeks a review of those final adverse determinations from the Director.

### III. ISSUE

Did Humana correctly deny coverage for the laboratory services and anesthesia?

### IV. ANALYSIS

#### Petitioner's Argument

In his external review request for the May 8, 2014 laboratory services, the Petitioner said:

I got treatment in [REDACTED] on May 20, 2014 and I got that time Humana healthcare and [Medicaid] and suppose either hospital or Humana informed me in advance that this service is not included in their policy, moreover, I am senior citizen now with low income as well and I am unable to pay the amount of \$428.00.

In his external review request for the July 8, 2014 date of service, the Petitioner said:

I was treated in [REDACTED] on July 08-2014 due to bleeding ulcers that time. I got Humana health care and Medicare that time of service. Humana did not inform me the time I became a member with them, what is included and what is not included in their service, therefore, either Humana or Medicare or both have to cover that service. Medical service was anesthesia. I am low income and I am unable to pay that amount of \$875.00.

#### Respondent's Argument

In its April 22, 2015 final adverse determination denying coverage for the anesthesia services, Humana explained its decision to the Petitioner:

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

The services rendered on July 8, 2014, were rendered by a non-network provider in a non-network facility and the services were not authorized by Humana. The Access to Care provision of the policy indicates our authorization must be obtained before receiving services from a non-network provider, unless such authorization cannot reasonably be obtained. Therefore, the anesthesia services . . . were correctly denied according to the General Exclusions of the policy. . . .

In its April 27, 2015 final adverse determination regarding denial of coverage for laboratory services, Humana explained its decision to the Petitioner:

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

The services rendered on May 20, 2014, were rendered by a non-network provider in a non-network facility and the services were not authorized by Humana. The Access to Care provision of the policy indicates our authorization must be obtained before receiving services from a non-network provider, unless such authorization cannot reasonably be obtained. Therefore, the laboratory services . . . were correctly denied according to the General Exclusions of the policy. . . .

Director's Review

Regarding the use of non-network providers, the policy (p. 16) says:

**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.

The policy also has these exclusions under “General Exclusion” (p. 39):

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. The following services are medically necessary to render emergency care;
    - 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 it clear that non-network services are generally covered only when they are authorized in advance by Humana.<sup>2</sup> It is the Petitioner’s responsibility to verify the network status of the provider and obtain the authorization. The policy (p. 14) 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] and [REDACTED], non-network providers, because no advance authorizations had been obtained.

**V. ORDER**

The Director upholds Humana’s April 22 and April 27, 2015 final adverse determinations.

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<sup>2</sup> There is nothing in the record to show that the Petitioner received emergency care, which is exempt from the requirement of prior authorization, or was otherwise unable to obtain prior approval for the services he 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 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:

A handwritten signature in black ink, appearing to read 'RS Gregg', is written over a horizontal line.

Randall S. Gregg  
Special Deputy Director