

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. 148690-001

Humana Medical Plan of Michigan, Inc.,

Respondent.

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Issued and entered  
this 30<sup>th</sup> day of July 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On July 6, 2015, ██████████ (Petitioner) filed a request 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 Petitioner receives health care coverage 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 determinations. Humana submitted material on July 10, 2015, and the Director accepted the request on July 13, 2015.

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 are defined in Humana's *Individual Medical Policy* (the policy).

On January 27, 2015, the Petitioner had an office visit at the ██████████  
██████████ (the Institute) where she had a foot x-ray, nail debridement, and a trigger point

injection. On February 3, 2015, she returned to the Institute and received another injection. The Institute is not in Humana's provider network. The charge for all these services was \$440.00.

Humana denied coverage for all the services because they were rendered by an out-of-network provider without advance approval from Humana.

The Petitioner appealed the denials through Humana's internal grievance process. At the conclusion of that process Humana maintained its denial in two final adverse determinations dated May 15, 2015 (for the January date of service), and June 16, 2015 (for the February date of service). The Petitioner now seeks a review of those final adverse determinations from the Director.

### III. ISSUE

Did Humana correctly deny coverage for the medical services rendered at the Institute?

### IV. ANALYSIS

#### Respondent's Argument

In its May 15, 2015, final adverse determination Humana explained to the Petitioner:

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

According to your policy our authorization must be obtained before receiving services from non-network providers. We do not show an authorization on file. Therefore, the claim was denied.

In its June 16, 2015, final adverse determination Humana further explained to the Petitioner:

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

According to our records, claim [*for the February 3, 2015, date of service*] was processed correctly according to their terms and provisions of your policy. . . .

The policy states an authorization must be obtained from us prior to receiving non-emergency room services from a non-network provider. It goes on to state that in the event that a network provider is unable to provide cover 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 authorization from us for non-network services before the care is rendered. Only those services authorized by us in advance to be provided by a non-network provider will be covered expenses.

Additionally, it states that it is the member's responsibility to verify the network participation status of all providers prior to receiving all non-emergency room services. The verification should be done only with us, by either calling the telephone number on your identification card or by accessing your network details on our website.

### Petitioner's Argument

The Petitioner acknowledges that she went to an out-of-network provider but she explained her reason for doing so in an April 13, 2015, appeal letter to Humana that she submitted with her external review request:

On January 27, 2015, I was seen by my primary doctor. . . . During my visit . . . she determined my foot pain was acute and I was unable to walk without extreme pain. She also stated that I needed to see a podiatrist immediately to address my foot pain. The [REDACTED] Institute" was able to schedule an appointment and see me immediately (same day).

Prior to my visit to the [REDACTED] Institute, I contacted Humana and spoke with a representative and was given a telephone number for [the Institute] to call for approval prior to seeing me. I assumed the doctor's was given an approval for me to be seen.

I followed all of the procedures that were given to me which included a number for podiatrist office to call Humana, prior to seeing me.

I assumed during my waiting period in the lobby that [REDACTED] Institute had followed the correct procedures and received approval from Humana. I was not aware of any charges that were not covered by Humana until I received a bill...

I am making an appeal to reverse these charges due to no fault of mine. I did not go outside of the network without first contacting Humana for guidance and approval to address my acute pain at the time. Please take all of the information into consideration as stated above and waive the charges for the emergency care I received.

### Director's Review

The policy, under "Access to Care" (p. 19), has this provision regarding the use of non-network providers and prior authorization requirements:

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

\* \* \*

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 (p. 42):

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; . . .

It is undisputed that the Petitioner received services from a non-network provider in January and February 2015. It is also undisputed that the Petitioner did not obtain advance authorization from Humana for those services (she assumed the provider would seek Humana's approval). Therefore, under the terms of the policy quoted above, the services she received at the Institute are not covered benefits and the charges remain the Petitioner's responsibility.

Emergency care from a non-network provider does not require advance authorization from Humana, and the Petitioner, in her April 13, 2015, letter to Humana, described the

treatment she received at the Institute as “emergency care.” However, the policy (p. 42) says that the emergency care exception to the advance authorization requirement applies only to medically necessary ambulance transport or services received in an emergency room or urgent care center. None of those exceptions apply in this case.

The Director concludes and finds that Humana correctly denied coverage for the services the Petitioner received on January 27, and February 3, 2015, at the Institute.

**V. ORDER**

The Director upholds Humana’s May 15 and June 16, 2015, final adverse determinations.

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

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

In the matter of:

Patricia A. Bradley,  
Petitioner,

File No.: 148690-001

v

Humana Medical Plan of Michigan,  
Respondent.

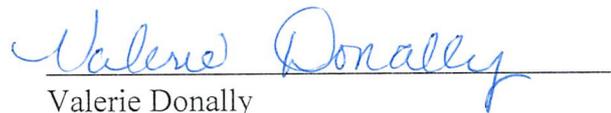
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PROOF OF SERVICE

Valerie Donally, being duly sworn, says that on July 30, 2015, she served a copy of the Order upon the following parties by depositing the same in an United States Postal Depository in the City of Lansing, Michigan, enclosed in an envelope, first class mail, bearing postage prepaid, plainly addressed as follows:

Andrea Harvel, Manager Grievance & Appeal  
Humana Insurance Company  
1100 Employers Blvd.  
Green Bay, WI 54344

Patricia A. Bradley  
14229 Vassar Avenue  
Detroit, MI 48235

  
Valerie Donally

Subscribed to and sworn before me on July 30, 2015.

  
Tracy A. Janousek, Notary Public  
Eaton County, Michigan  
Acting in Ingham County, Michigan  
My commission expires: 04/03/2019