

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. 148763-001

Humana Medical Plan of Michigan, Inc.
Respondent.

Issued and entered
this 3rd day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

The Patient's Right to Independent Review Act (MCL 550.1901 *et seq.*) authorizes the Director of Insurance and Financial Services to review denials of coverage for health care services. These external reviews are initiated by policyholders or an authorized representative once a coverage denial has been reviewed by the insurer in its internal grievance process.

On July 10, 2015 ██████████ (Petitioner) filed a request for an external review with the Director of Insurance and Financial Services. The Petitioner receives health care coverage through Humana Medical Plan of Michigan, Inc., a health maintenance organization. The benefits are defined in Humana's *Individual Medical Policy*.

The Director notified Humana of the external review requests and asked for the information it used to make its final adverse determination. Humana submitted material on July 15, 2015. The Director accepted the request on July 17, 2015.

This review can be resolved by an analysis of Humana's *Individual Medical Policy*. The Director reviews contractual issues pursuant to MCL 550.1911(7). This review does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On November 3, 2014, the Petitioner had a screening mammogram at ██████████
██████████ Hospital. The charge was \$225.00. On November 7, 2014, the Petitioner returned to ██████████

██████████ for a follow-up mammogram and ultrasound. The charge was \$503.00. ██████████ is not in Humana's provider network. Humana denied coverage, ruling that the services were rendered by an out-of-network provider without the required prior authorization.

The Petitioner appealed the denials through Humana's internal grievance process. At the conclusion of that process Humana maintained its denial in a final adverse determination dated June 16, 2015. The Petitioner now seeks a review of this final adverse determination from the Director.

III. ISSUE

Did Humana correctly deny coverage for the Petitioner's November 3 and 7, 2014 services provided by ██████████

IV. ANALYSIS

Petitioner's Argument

In his request for an external review, the Petitioner wrote:

On Nov 3rd and 7th 2014 I had a mammogram and followup ultrasound. In the past I have had my mammograms at ██████████ Hospital where my records are thus that is where I went to have it done. I have since discovered they are not within the Humana Network. This was not explained to me when I made the appointment nor did I sign any waiver stating I was aware of this and assume payment.

Respondent's Argument

In its June 16, 2015 final adverse determination denying coverage for the November 3 and November 7, 2014 medical services, Humana explained to the Petitioner:

██████████ Hospital is not in network with your plan and no authorization was obtained to use this hospital. Therefore, the claims denied correctly as shown in the enclosed Health Benefit Processing Chart.

The policy states on page 16 in the section titled Access to Care; 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.

Director's Review

Regarding the use of non-network providers, the Petitioner's policy (page 16) provides:

3. ACCESS TO CARE

* * *

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.

* * *

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 at 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 the cost incurred.

On page 39 the policy provides:

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....

There is nothing in the record to show that the Petitioner received emergency care, which is exempt from the prior authorization requirement, nor was prior authorization granted for the services received. The policy does not provide for any exception to the prior authorization requirement which might apply to the Petitioner's situation. The Director finds that Humana correctly applied the terms of the policy when processing the Petitioner's claims.

V. ORDER

The Director upholds Humana's June 16, 2015 final adverse determination.

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:



Randall S. Gregg
Special Deputy Director