

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 102718-001

v

Humana Insurance Company
Respondent

Issued and entered
this 26th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 3, 2009, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner accepted the request on March 10, 2009.

The Commissioner notified Humana Insurance Company of the external review and requested the information used in making its adverse determination. The information was received on March 10, 2009.

The issue here can be decided by an analysis of Humana's certificate of insurance, the contract defining the Petitioner's health 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 August 14, 2008, the Petitioner was involved in a bicycle accident and sustained facial lacerations and a broken jaw. She was taken that day to the emergency room (ER) of a hospital in Grand Rapids. While at the ER, she received services from two on-call specialists, an oral surgeon and a plastic surgeon. On September 26, 2008, the oral surgeon saw the Petitioner to remove pins and wires. Neither of the two specialists was in Humana's network of providers.

The Petitioner was dissatisfied with Humana's processing of the claims for these services and appealed. Humana reviewed the claims but, at the completion of the internal grievance process, upheld its decision and sent a final adverse determination dated January 12, 2009.

III ISSUE

Did Humana correctly process Petitioner's claims?

IV ANALYSIS

Petitioner's Argument

The Petitioner is unhappy with Humana's processing of her claims for an emergency that has left her responsible for out-of-pocket expense. She says that she had no choice in the matter of who the on-call providers were on the day she went to the ER. She feels she should not have to pay any out-of-network sanctions when she went to a network hospital for her emergency care and asks that Humana pay the charges for her care at the amount billed by the providers.

Respondent's Argument

Humana says that it covered the Petitioner's ER care on August 14, 2008, at the network level even though the two physicians were not in its network because of this provision in the certificate of insurance:

Emergency services

We will pay benefits for covered expenses incurred by you for emergency care, including the treatment and stabilization of an emergency medical condition.

Emergency care provided by a non-network hospital or a non-network health care practitioner will be covered at the network provider benefit percentage, subject to the maximum allowable fee. Non-network providers have not agreed to accept discounted or negotiated fees, and may bill you for charges in excess of the maximum allowable fee. You may be required to pay any amount not paid by us. [Underlining added]

Humana covers network claims at 100% of the benefit payable after the network deductible has been satisfied. Non-network services are covered at 70% of the benefit payable after the non-network deductible has been satisfied.

Humana initially processed the ER physician claims in error as non-network services. However, in December 2008 it reprocessed them as network claims, which reduced the Petitioner's out-of-pocket expense by \$1,115.79.

Even though the services were for an emergency and covered at the network benefit percentage, the claims were still subject to Humana's maximum allowable fee (MAF) for the services. In this case, since the two non-network providers had not contracted with Humana to provide services for a negotiated fee, Humana established the MAF "by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us" (see p. 94 of the certificate of insurance). The certificate of insurance contains this warning (p. 94):

The bill you receive for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to deductibles, copayments and coinsurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services.

Regarding the Petitioner's follow-up care with the oral surgeon on September 26, 2008, Humana says that service "was after the emergency situation had been stabilized, therefore is not categorized as an emergency situation." Therefore, Humana processed that claim as a non-network service and applied the entire maximum allowable fee to the Petitioner's non-network

deductible.¹

Humana believes it has correctly processed the Petitioner's claims according to the terms and conditions of the certificate of insurance.

Commissioner's Review

The Petitioner is understandably displeased by the fact that she went to a network hospital and still incurred significant out-of-pocket expenses because non-network providers were on call and she had no choice but to use them.

Unfortunately, nothing in the certificate of insurance compels Humana to pay a non-network provider's charge if it exceeds the MAF for a service, even in an emergency. Under the certificate of insurance, Humana covers emergency treatment at the network level but even so it is not obligated to pay a non-network provider's entire charge.

This table shows how Humana finally processed the claims for both dates of service:

Date of Service and Provider	8/14/08 (Oral Surgeon)	8/14/08 (Plastic Surgeon)	9/26/08 (Oral Surgeon)	Petitioner's Responsibility
Provider's Charge	\$ 3,043.00	\$ 640.00	\$ 830.00	
Not Covered (Amount Over Humana's Maximum Allowable Fee)	1,556.90	337.60	440.10	\$ 2,334.60
Humana's Maximum Allowable Fee (MAF)	1,486.10	302.40	389.90	
Applied to Deductible	345.12		389.90	735.02
Amount Paid by Humana	1,140.98	302.40		
			Total	\$ 3,069.62

The emergency care the Petitioner received on August 14, 2008, was covered at the network level of benefits, which meant that Humana paid 100% of its MAF after the network deductible was satisfied (\$345.12 was applied to the network deductible). However, under the terms of the certificate of insurance, the Petitioner is still responsible for any difference between the non-network provider's charge and the MAF.

¹ In October 2008 Humana processed the claims in error and did not apply any amount toward the \$4,000.00 non-network

There is nothing in the record to show that the care on September 26, 2008, was for emergency services. Thus, it was correctly processed at the non-network level and the entire MAF was applied to the non-network deductible, which had yet to be met. Here, too, the Petitioner is responsible for any difference between the provider's charge and the MAF.

The Commissioner concludes and finds that Humana has correctly processed the claims for the Petitioner's services from non-network providers.

IV ORDER

The Commissioner upholds Humana's final adverse determination of January 12, 2009.

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 sixty 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, P. O. Box 30220, Lansing, MI 48909-7720.

deductible. In April 2009 it reprocessed the claim and applied the entire maximum allowable fee to the Petitioner's \$4,000.00 non-network deductible, which had not been met for 2008.