

**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. 152299-001**

**Humana Medical Plan of Michigan, Inc.**

**Respondent.**

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**Issued and entered**  
**this 15<sup>th</sup> day of March 2016**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) was dissatisfied by the way his health plan, Humana Medical Plan of Michigan, Inc. (Humana), processed claims for anesthesia services.

On February 19, 2015, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of Humana's action under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health benefits through an individual medical policy from Humana. The Director immediately notified Humana of the external review request and asked for the information it used to make its final adverse determination. Humana responded on February 23, 2016. After a preliminary review of the material received, the Director accepted the Petitioner's request on February 26, 2016.

This case presents an issue of contractual interpretation. The Director 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**

The Petitioner's health care benefits are described in a document called *Individual Medical Policy* which includes riders, amendments, and notices (the policy).

On July 27, 2015, the Petitioner had a surgical procedure. Anesthesia services for the surgery were performed by a physician and a certified registered nurse anesthetist (CRNA), both non-network providers. The two providers charged a total of \$2,093.00.

According to the explanation of benefits and claim payments statements, Humana covered the anesthesia services as an in-network service and paid the two providers a total of \$1,046.50 (50% of the charges). The two providers billed the Petitioner for the balance of their charges or \$1,046.50.<sup>1</sup>

The Petitioner appealed Humana's claims processing decisions through its internal grievance process. At the conclusion of that process, Humana issued a final adverse determination dated February 4, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did Humana correctly process the claim for the Petitioner's anesthesia services?

### IV. ANALYSIS

#### Petitioner's Argument

In the request for an external review the Petitioner said:

The resolution I am seeking would be either the balance due to be paid off or the charges dropped. I was told the procedure would be covered thru Humana. No one told me anesthesia was billed separately which is charging the equivalent of \$3,000.00 per hour. I only earn around \$20,000/year. . . . This balance of \$1050.00 is approximately 5% of my annual income! This unfair practice of theirs via the bill would cause me great financial harm. If I would have known then I would not have had the procedure.

#### Respondent's Argument

In its final adverse determination, Humana explained its decision to the Petitioner:

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

We were unable to approve additional benefits for the anesthesia services because claims were processed correctly according to the terms and provisions of the plan.

. . .

When an anesthesiologist supervises a Certified Nurse Anesthetist (CRNA), Humana receives two claims for the anesthesia services. Humana allows 50

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<sup>1</sup> The Petitioner was billed for \$1,050.00 which appears to be incorrect.

percent of the anesthesiologist's contracted rate or usual and customary for each provider, thereby not allocating more than 100 percent of the total allowed expense. Your benefit plan document states that services performed by an anesthesiologist will be paid at your in-network level of benefits, as long as the facility where the services are performed is in-network.

**The policy states:**

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

11. Services exceeding the amount of benefits available for a particular service.

Director's Review

The Petitioner had surgery at an in-network facility. However, he did not know that the anesthesia services would be rendered by non-network providers. The policy (p. 19) explains the use of non-network providers:

Not all healthcare practitioners who provide services at network hospitals are network healthcare practitioners. If services are provided by non-network pathologists, anesthesiologists, radiologists, and emergency room physicians at a network hospital, we will pay for those services at the network provider benefit level. Non-network healthcare practitioners may require payment from you for any amount not paid by us. If possible, you may want to verify whether services are available from network healthcare practitioners. [Underlining added]

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. . . .

The policy (p. 17) also explains that network providers have agreed to accept Humana's contracted or negotiated fee for a covered service and cannot bill for any charges in excess of that fee. However, non-network providers are free to bill for any amount not paid by Humana.

The policy recognizes that not all providers at network facilities are themselves in-network. When that is the case, as it is here, Humana pays for covered non-network services as though they were performed by network providers. But the non-network providers may still bill for any difference between their charge and Humana's payment.

The Petitioner is understandably aggrieved because he is now responsible for significant out-of-pocket expense for services from a non-network provider. However, the amount paid by Humana for the claims at issue in this case is in accord with the terms and conditions of the Petitioner's coverage.

**V. ORDER**

The Director upholds the February 4, 2016, 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:

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

Randall S. Gregg  
Special Deputy Director