STATE OF MICHIGAN

COURT OF APPEALS

MIC GENERAL INSURANCE CORPORATION,

Plaintiff-Appellant,

v

HEALTHPLUS OF MICHIGAN, INC.,

Defendant-Appellee.

UNPUBLISHED
December 16, 1997

No. 196207
Genesee Circuit Court
LC No. 95-37810-CZ

Before: Markman, P.J., and McDonald and Fitzgerald, JJ.

PER CURIAM.

Plaintiff appeals the trial court's order granting defendant's motion for summary disposition pursuant to MCR 2.116(C)(10), which determined that defendant was not responsible to reimburse plaintiff for medical benefits paid by plaintiff to a common insured. We reverse and remand.

Judy Fuller was insured both by plaintiff, as her no-fault insurance carrier, and by defendant, as her health care insurer. Both policies contained coordination of benefits provisions, relegating each to the status of an excess insurer. On or about October 16, 1993, Judy Fuller was involved in an automobile accident and suffered serious physical injuries that left her a quadriplegic. She was taken to Hurley Medical Center (Hurley) for emergency treatment of her broken neck and cervical spine fracture. Dr. Mark Clark, Mrs. Fuller's primary care physician under the terms of defendant's HMO, was not on the staff at Hurley and did not participate in treating her condition. Defendant paid approximately $100,000 for Mrs. Fuller's treatment at Hurley because the services were rendered on an emergency basis. After her initial treatment, Judy Fuller's husband, Joseph Fuller, discussed rehabilitation options with his wife's treating physicians at Hurley and Dr. Clark. On November 9, 1993, Mrs. Fuller was admitted to the Craig Institute (Craig), an inpatient rehabilitation facility located in Englewood, Colorado. Craig is not affiliated with defendant's HMO. Eight weeks after her admission to Craig, Judy Fuller was completely recovered, no longer a quadriplegic.

The fee for the services rendered by the Craig Institute totaled approximately $76,000. Plaintiff paid this cost and sought reimbursement from defendant. When defendant refused, plaintiff filed the present action. Plaintiff claimed that under its policy and Michigan law, it was merely an excess provider, and defendant was primarily responsible for payment of health care

benefits. Defendant then filed its motion for summary disposition, arguing that it was not required to pay for the expenses incurred at Craig because it had not referred Judy Fuller to Craig, and, absent a referral, the services were excluded under its HMO contract. The trial court agreed, and dismissed plaintiff's claim pursuant to MCR 2.116(C)(10).

On appeal, this Court reviews a trial court's grant of summary disposition de novo. *Fitch v State Farm Fire and Casualty Co*, 211 Mich App 468, 470; 536 NW2d 273 (1995). This Court considers the entire record, including pleadings, affidavits, depositions, and admissions, viewing all evidence in the light most favorable to the non-moving party. *Id.* The party moving for summary disposition pursuant to MCR 2.116(C)(10) is entitled to judgment as a matter of law only if there is no genuine issue of any material fact. *Bourne v Farmers Ins Exchange*, 449 Mich 193, 196-197; 534 NW2d 491 (1995).

Michigan's no-fault act requires an insurer to offer its insureds the option to pay reduced premiums in exchange for coordinating their personal protection benefits with their other health and accident coverage.[1] MCL 500.3109a; MSA 24.13109(1); *Westfield Co v Grand Valley Heath Plan*, ___ Mich App ___; ___ NW2d ___ (Docket No. 178642, issued 07/08/97), slip opinion at 2. When the insured elects this option to coordinate their benefits, the insured's health carrier becomes the primary insurer for any physical injuries sustained in a motor vehicle accident, even where the health insurance policy also contains a coordinated benefits clause. *Federal Kemper Ins Co, Inc v Health Ins Administration, Inc*, 424 Mich 537, 545-546; 383 NW2d 590 (1986), overruled in part on other grounds, *Auto Club Ins Assoc v Frederick & Herrud, Inc*, 443 Mich 358; 505 NW2d 820 (1993); *Transamerica v IBA Health*, 190 Mich App 190, 193-194; 475 NW2d 431 (1991). However, the health insurer is only primarily liable "to the extent [it] has agreed to pay for or provide [the] necessary medical care." *Westfield, supra* at 2, citing *Tousignant v Allstate Ins Co*, 444 Mich 301, 308; 506 NW2d 844 (1993). The Coordination of Benefits Act, MCL 550.251, *et seq.*; MSA 24.13671, *et seq.*, provides:

> A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract. [MCL 550.253(4); MSA 24.13673(4).]

In the present case, defendant's contract with Judy Fuller explicitly excluded:

> Services not provided by or under the direction of the Member's Primary Care Physician, except Emergency Health Services and/or services rendered by a Non-Affiliated Provider after being Appropriately Referred.

Neither party disputes that Judy Fuller's rehabilitation at Craig constituted a service rendered by a non-affiliated provider. As the trial court correctly found, it is also clear from the record that defendant HMO did not provide a referral for the treatment. However, this Court has recently indicated that this does not always end the inquiry whether the HMO will be held primarily responsible for the insured's medical expenses. In *Westfield, supra* at 3,[2] this Court held that it would elevate form over substance to allow an HMO to deny coverage of expenses for medically necessary services simply because the HMO did not, in accordance with its contract, approve the expenses in advance. There, this Court ruled that the trial court erred in granting summary

disposition without first considering whether the HMO's denial was unreasonable. *Id.*, 2. In *Westfield, supra*, the defendant HMO conceded the treatment sought by the insured was necessary and appropriate, and there were no allegations that the insured simply chose to seek treatment from non-participating providers like the insured in *Tousignant, supra*. We interpret *Westfield, supra*, as a safeguard to be utilized in those cases where there is evidence a health insurer is attempting to avoid its primary responsibility for payment of medical expenses, which is against the public policy of this State expressed in *Federal Kemper, supra*. In those cases, it may be necessary to refuse to enforce the contract between the health insurer and the insured in order to give effect to this stated public policy.

In this case, it appears that inpatient rehabilitation services were included as covered benefits under § 5.2(J) of defendant's Group Subscriber Contract. The parties appear to agree that Mrs. Fuller was in need of rehabilitation services. However, we are unable to ascertain from the record whether defendant HMO offered the Fullers any rehabilitation services. There is conflicting evidence in the record whether a referral to Craig or any other rehabilitation facility was ever processed by defendant HMO. Mr. Fuller testified at deposition that defendant HMO denied a referral to Craig because appropriate services were available at Hurley.[3] However, defendant HMO's nurse reviewer, Connette Sams, testified at deposition that no denial was ever made because no referral was ever requested. Dr. Clark testified at deposition that he was never asked to make a referral to any rehabilitation facility. Although there was evidence in the record that Mr. Fuller did decide to admit his wife to Craig knowing he did not have the necessary referral from defendant HMO, in light of the incomplete record, it is impossible for this Court to determine whether it should apply *Westfield, supra*, or *Tousignant, supra*, to this case. Therefore, we find the trial court's grant of summary disposition was inappropriate. In light of our disposition of this case, we do not address plaintiff's other arguments.

Reversed and remanded. We do not retain jurisdiction.

/s/ Gary R. McDonald
/s/ E. Thomas Fitzgerald

[1] Coverage under an HMO is considered health and accident coverage under this statute. *Calhoun v Auto Club Ins Ass'n*, 177 Mich App 85, 90; 441 NW2d 54 (1989).

[2] The trial court did not have the benefit of this Court's decision in *Westfield, supra*, because the case was not released at the time the trial court ruled.

[3] We note that the trial court incorrectly found that there was treatment available within defendant's HMO. There was no evidence in the record that Hurley was a participating provider with defendant's HMO and no evidence that any rehabilitation facilities participated in the plan.

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MARKMAN, J. (concurring).

I concur with the majority that this case should be reversed and remanded. However, I would do so exclusively in order to determine whether a referral to the Craig Institute or any other rehabilitation facility was ever sought by the Fullers. If such a request for referral was made, then I believe that the medical reasonableness of defendant's denial of the referral under the Group Services Contract must be determined.[1] It is implicit in the HMO contract that decisions to refer or to not refer must be reasonably grounded lest the health insurer routinely be able to shift costs to the no-fault insuror where personal protection benefits have been coordinated with other health and accident coverage. *Federal Kemper Ins Co, Inc v Health Ins Administration, Inc*, 424 Mich 537, 546; 383 NW2d 590 (1986); *Michigan Mutual Ins Co v American Community*, 165 Mich App 269, 274-275; 418 NW2d 455 (1987). Such an inquiry into the medical reasonableness of a referral decision would include an evaluation of Judy Fuller's injuries as well as the respective medical resources available to her inside and outside of the HMO.

However, if a request for referral was not made by the Fullers pursuant to the HMO contract, then this is the end of the trial court's inquiry, in my judgment, and it must grant summary disposition in favor of defendant.[2] It is well-understood that a party entering into a contract for medical services with an HMO thereby sacrifices some measure of their freedom with regard to their choice of provider. While they remain free to obtain the services of any provider they choose, they are entitled to reimbursement from the HMO only to the extent that such provider is either within the purview of the HMO or else is a non-affiliated provider who has been specifically authorized by the HMO pursuant to its own procedures. To the extent that *Westfield Co v Grand Valley Health Plan*, 224 Mich App 385; 568 NW2d 854 (1997) supports the proposition that HMO contract provisions need not be construed in the same manner as other contract provisions because to do so would potentially be to place "form over substance," I

respectfully reject this holding and abide by it only under the requirements of MCR 7.215(H). Further, I would retain jurisdiction.

/s/ Stephen J. Markman

[1] This would also encompass an assessment of the reasonableness of defendant's conduct either in failing to act upon a proper referral request or in failing to comply with its own procedures established in connection with referral requests.

[2] An exception might obtain if there were emergency medical care provisions in the HMO contract that arguably applied to the instant circumstances. I am not aware, however, of any such provisions having been invoked by plaintiff or by the Fullers.