

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. 152200-001

HealthPlus Insurance Company,

Respondent.

Issued and entered
this 9th day of March 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) disputes the way her health insurer, HealthPlus Insurance Company (HealthPlus), processed claims for physical therapy visits in March and April 2015.

On February 16, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of HealthPlus's claims processing decisions under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

From February 1, 2014, through December 31, 2015, the Petitioner received health care benefits through an individual plan underwritten by HealthPlus. The Director immediately notified HealthPlus of the external review request and asked for the information it used to make its adverse determination. HealthPlus responded on February 16, 2016. After a preliminary review of the material received, the Director accepted the Petitioner's request on February 23, 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 defined in the HealthPlus *Signature PPO Individual Certificate of Coverage* (the certificate).

The Petitioner has De Quervain's tenosynovitis, a condition affecting the tendons on the thumb side of the wrist. After failing conservative treatment, she had surgery in February 2015 to repair the condition and was told she would need to follow up with therapy.

Between March 17 and April 14, 2015, the Petitioner had twelve physical therapy (PT) visits billed by Midwest Hand Therapy. HealthPlus covered the therapy but applied its approved amount for the services to the Petitioner's unmet \$6,000.00 deductible for out-of-network services.

The Petitioner, believing the therapy should be covered as in-network services, appealed through the HealthPlus internal grievance process. At the conclusion of that process, HealthPlus issued a final adverse determination dated January 5, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did HealthPlus correctly process the claims for the Petitioner's PT therapy?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination, HealthPlus told the Petitioner:

HealthPlus Insurance Company (HPI) staff has reviewed your grievance requesting . . . payment of claims for physical therapy (PT) services rendered to you by [REDACTED], an out-of-network provider, for dates of services March 17, 2015 through April 14, 2015. . . . Your case has been reviewed by Health Plus' Director of Customer Service, with seventeen years of experience in the health care industry. She has determined to deny your first request and approve your second request.

Her decision to deny your request concerning payment of your PT claims is based on your enclosed Schedule of Benefits (SOB), section Short-Term Outpatient Rehabilitation Services, which states Member Responsibility [Out-of-Network]: 50% after Deductible met plus Excess Charges.

This decision is further supported by your enclosed Certificate of Coverage (COC), **Section V – Accessing Covered Services**, (5.2) Provider of Choice, which states

- A. Members may receive Health Care Benefits from any Provider the Member Chooses. However, if a Member receives Health Care Benefits from a Non-Preferred Provider, the Member will be responsible for paying higher Copayments, Coinsurance, and Deductibles. Members should refer to the Schedule of Benefits and any applicable Riders for further information.

As an explanation, HPI must process claims based on information submitted, which includes the servicing provider's billing information in the form of a National Provider Identification (NPI) and/or taxonomy identification number (tax ID). Our records indicate

that the claims for your PT were submitted with the NPI and tax ID for [REDACTED]. Because they are an out-of-network provider, the claims were processed according to your out-of-network benefits, as outlined above. Though you indicated services were rendered in the office of your treating physician, [REDACTED] is a separate provider located within the same facility as [REDACTED] practice. If you feel the billed information is incorrect, we encourage you to contact [REDACTED] to discuss your concerns. It would be fraudulent for HPI to alter the integrity of submitted claims.

Petitioner's Argument

The Petitioner explained her argument in an undated statement submitted with her external review request:

On March 16, 2015, I requested the staff of [REDACTED], a HealthPlus in-network preferred PPO provider, to contact HealthPlus to confirm that occupational therapy services recommended by [REDACTED] and which would take place within her office . . . would be processed as in-network and covered under my policy. [REDACTED] office advised me on March 16, 2015 that HealthPlus had confirmed that the services would be covered and processed as in-network. Based on this representation, I began a series of twelve (12) occupational therapy sessions which occurred between March 17, 2015 and April 14, 2015. On April 17, 2015, I began receiving HealthPlus Explanation of Benefits indicating that [REDACTED] was a non-preferred provider and the related charges were posted to my out-of-network deductible. In my discussions with HealthPlus in an attempt to resolve this conflict, I was advised that two separate Tax ID numbers were utilized by [REDACTED], one for office visits and another for therapy visits. On December 19, 2015 I filed a Grievance Report requesting the services be processed as in-network based on the March 16, 2015 conversation between HealthPlus and [REDACTED] office. On January 5, 2016, I received notification that the grievance request was denied. On January 15, 2016, I requested via fax a transcript of the March 16, 2015 conversation between [REDACTED] office and HealthPlus. On January 28, 2016, I was advised via telephone by HealthPlus that my request for the transcript had been denied as I was not a party to the conversation. It is my position that as a subscriber, I followed due diligence in seeking approval for in-network confirmation prior to treatment, and representations made by HealthPlus Customer Service should be considered as reliable information when making decisions regarding health care provider choices. Certainly, had the response from HealthPlus indicated the services would be billed as out-of-network, I would have explored other options.

Director's Review

The certificate (pp. 30-31) covers short term outpatient physical therapy when medically necessary. There is no dispute here that the physical therapy the Petitioner received was both a covered benefit and medically necessary. The issue here is how the claims were processed.

[REDACTED] is a non-preferred or out-of-network provider. The schedule of benefits

for the Petitioner's plan (p. 2 of 19) says that HealthPlus "pays 50% of Allowed Amount or Reasonable and Customary Amount for Out-of-Network Services after Deductible is met. Member pays Excess Charges." "Allowed amount" is defined in the certificate (p. 2) as

the maximum amount HPI will pay for a Covered Service furnished by a Preferred or Non-Preferred Provider. For a Non-Preferred Provider, the Allowed Amount is the lesser of the treating Provider's charge or the amount that HPI reasonably determines is usual and customary for the services provided.

HealthPlus determined that its allowed amount for the Petitioner's therapy from a non-preferred provider was \$1,064.67 and it applied that amount to the \$6,000.00 out-of-network deductible. Based on the foregoing, the Director concludes that HealthPlus correctly processed the claims for the physical therapy.

It is the Petitioner's contention that a HealthPlus representative inaccurately told her physician's office that the physical therapy would be processed as in-network services. Even if that is true, in this review under the Patient's Right to Independent Review Act the Director may only decide whether HealthPlus properly administered health care benefits according to the terms and conditions of the certificate.

██████████ is an out-of-network provider. HealthPlus processed the claims as out-of-network services subject to the out-of-network deductible. The Director finds that HealthPlus accurately processed the claims according to the terms of the Petitioner's certificate and schedule of benefits.

V. ORDER

The Director upholds HealthPlus Insurance Company's January 5, 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 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