

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. 152795-001

HealthPlus Insurance Company,
Respondent.

Issued and entered
this 13th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 22, 2016, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on March 29, 2016.

The Petitioner receives health care benefits through an individual plan underwritten by HealthPlus Insurance Company (HealthPlus). The Director immediately notified HealthPlus of the external review request and asked for the information it used to make its final adverse determination. HealthPlus responded on April 6, 2016.

The issue in this external review can be decided by a contractual review. 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 HealthPlus's *Signature PPO Individual Certificate of Coverage* (the certificate).

In 2014 the Petitioner had female-to-male gender reassignment surgery. On October 21,

2015, the Petitioner's surgeon requested authorization from HealthPlus to perform additional surgery. The request was denied on October 22, 2015. The Petitioner proceeded with the surgery on November 10, 2015, described in the operative report as "scar revision of penis and scrotum and reposition of left testicular implant."

The Petitioner appealed HealthPlus's denial through its internal grievance process. At the conclusion of the process, HealthPlus affirmed the denial and issued a final adverse determination dated February 22, 2016. The Petitioner is now seeking a review of that final adverse determination from the Director.

III. ISSUE

Did HealthPlus correctly deny the Petitioner's surgery on November 10, 2015?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form, the Petitioner wrote:

I had contacted HealthPlus before going in for a scar revision surgery. The insurance company affirmed that the surgery was covered by my plan. My Dr.'s office called and spoke with HealthPlus giving them both the surgery and diagnosis codes and was told it was covered. HealthPlus denied my surgery shortly before I was scheduled. Personal costs such as plane tickets, nurse help, and a flight ticket for the nurse, room scheduling and surgery were already scheduled. I am requesting \$3,000 reimbursement for surgery.

In a letter dated March 17, 2016, the Petitioner also stated:

I do not feel that this was a gender reassignment related surgery, as this procedure happened not after gender surgery but was a surgery in the genital area after I had already had a scar revision surgery to fix a scar revision. So we are talking two surgeries after any gender surgery, and not a sex reassignment surgery.

Plus I had done my very best to contact Health Plus regarding the surgery to get authorization, and so did the surgeon's office. We both were told that I was covered. Based on this information I arranged housing, a hospital surgery date, airfare nonrefundable tickets for both my nurse care aide and myself to travel. I had to arrange to take two weeks off work, and planned for food and other transportation costs.

My left testicular implant was painfully up high under the penis and needed to be repaired. Upon receiving Health Plus change of decision denial letter for coverage well after I had as well as the surgeon's office had received appeal everything had been scheduled. To drop surgery would [have] been costly and the surgery was needed. I completely planned and arranged to travel entirely based on Health Plus's reassurance that I would be covered. So feel that it is right to request Health Plus to reconsider over turning their denial decision because I do not believe that this surgery would qualify for being a gender reassignment related surgery, because I had contacted Health Plus as did the surgeon's office both receiving conformation of approval of coverage, the surgeon's office gave both the surgery and diagnosis codes, costs that I could not get back were paid before the change of decision letter, and I believe this surgery was necessary.

* * *

I am hoping that to receive financial compensation for out of pocket surgery costs \$1,700 and other medical costs I inquired such as housing, flight costs and food for a request of \$3,000.00 compensation.

I feel the decision made by Health Plus was unfair, as I believe that the decision of denial was neither fair after receiving multiple conformation of approval of coverage, nor right in that by then I had made arrangements and paid costs I could not get back containing to surgery and because this was a needed and I believe to be a surgery not gender reassignment related.

Respondent's Argument

In its final adverse determination to the Petitioner, HealthPlus's representative explained that the request for the proposed surgery was denied:

. . . Your case has been reviewed by HealthPlus's Director of Customer Service, with seventeen years of experience in the health care industry, and a Plan Medical Director, a D.O. board certified in Family Practice. It has been determined to deny your request.

* * *

Our records indicate that on October 22, 2015, the prior authorization request was received from [your surgeon's] office, which included clinical documentation in the form of medical records, including the operative report from the gender reassignment surgery you underwent in 2014. Based on the fact that the scar revision is secondary to the gender reassignment surgery, the prior

authorization request was denied as not a covered benefit of your plan. The denial of the prior authorization request was not indicating that you could not proceed with receiving services, only that HPI [*HealthPlus Insurance*] would not pay for them. HPI is not calling into question the medical necessity of the procedure you underwent. However, the terms of your [certificate] supersede medical necessity. Review of the call history indicates that you and [the hospital] had been advised well in advance that any / all services related to transgender / gender reassignment were not covered as a benefit of your plan.

Director's Review

The certificate has this provision (pp. 44, 46)

8.2 Exclusions from Coverage

Coverage for services and products not specifically identified by this Certificate or any applicable Rider are not Covered Services (even if Medically Necessary) including, but not limited to:

* * *

X, Sex transformation surgery and all expenses in connection with such surgery.

Based on this provision, the Director finds that the surgery on November 10, 2015, was an expense “in connection with” the gender reassignment surgery in June 2014 and is therefore excluded from coverage. The Director rejects the Petitioner’s argument that the surgery was not related to the prior gender reassignment surgery; the Petitioner’s own surgeon described it as a “further revision” of the earlier surgery in his preauthorization request in October 2015.

The Petitioner also argues that HealthPlus “authorized” his surgery in July 2015 and then changed its decision after he had relied on it, causing him to incur out-of-pocket expenses. However, it appears that in July 2015 the Petitioner’s providers only inquired about whether certain procedure codes required prior authorization. There is no evidence in this record that any preauthorization was requested or approved before October 21, 2015, nor is it shown that HealthPlus was aware in July 2015 that the surgeon’s inquiry related to an earlier transgender surgery.

In any event, the Director cannot order the relief the Petitioner seeks regarding his out-of-pocket expenses. There is no provision in the certificate allowing for those expenses and the Director, in this case, does not have the authority under the Patient’s Right to Independent Review Act to amend the terms of the Petitioner’s coverage to require benefits beyond those contained in the certificate.

The Director concludes and finds that HealthPlus's denial of coverage for the November 10, 2015, surgery is consistent with the terms of the certificate.

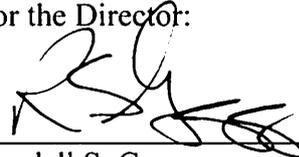
V. ORDER

The Director upholds HealthPlus's February 22, 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:



Randall S. Gregg
Special Deputy Director