

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. 149122-001

Golden Rule Insurance Company,

Respondent.

Issued and entered
this 31st day of August 2015
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) thought that his health insurance carrier erred when it processed the claim for his colonoscopy. On August 3, 2015, he filed a request with the Director of Insurance and Financial Services seeking an external review of the claim decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material received, the Director accepted the request on August 10, 2014.

The Petitioner receives medical benefits through a plan that is underwritten by Golden Rule Insurance Company (Golden Rule). The Director immediately notified Golden Rule of the external review request and asked for the information it used to make its final adverse determination.

To address the medical issues in the case, the Director assigned the matter to an independent medical review organization which provided its analysis and recommendation to the Director on August 24, 2014.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are described in a certificate of insurance issued by Golden Rule (the certificate).¹

¹ The Petitioner obtained the coverage through membership in the Federation of American Consumers and Travelers. It is called an "association group" plan but is considered to be individual coverage in Michigan.

The Petitioner, [REDACTED] years old at the time, had a colonoscopy on December 9, 2013. The service was covered but Golden Rule applied its approved amount of \$2,365.00 to the Petitioner's annual deductible, leaving the Petitioner responsible for that amount.

The Petitioner, believing there should be no out-of-pocket expense for the colonoscopy, appealed through Golden Rule's internal grievance process. At the conclusion of that process Golden Rule issued a final adverse determination dated July 16, 2015, affirming its original claim processing decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did Golden Rule correctly process the claim for the Petitioner's colonoscopy?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form the Petitioner said:

Golden Rule Insurance has denied payment for screening of colonoscopy procedure done 12-09-13 at University of Michigan Hospital that should be provided under the rules in the Affordable Care Act as preventive health care.

I called Golden Rule Insurance and University of Michigan Hospital to make sure that this colonoscopy will be 100% covered as preventive health care. I was assured by both that it was.

I am asking for a review and reverse Golden Rule Insurance decision denying payment to the University of Michigan Hospital.

Respondent's Argument

In its final adverse determination, Golden Rule explained its decision:

Your letter indicates under the Patient Protection and Affordable Care Act (PPACA), a colonoscopy is considered a preventive service. You believe the services from December 9, 2013, are eligible for reimbursement under your plan's Preventive Care Expense Benefits provision.

The submitted information was reviewed by a doctor Licensed Board Certified in Family Medicine. The reviewer explains that preventive health care is provided to asymptomatic individuals to screen for the presence of disease. In this case, the reviewer indicates that you are not an asymptomatic person as you are a high risk surveillance program of colonoscopies. Therefore, you are someone who has a

known disorder, colon polyps, which requires colonoscopies at time intervals that have been shortened from the usual ten years.

A review of your request was completed on July 16, 2015, by a panel of persons not previously involved in the original benefit determination. It is this decision of the reviewing panel to uphold the original reimbursement of the colonoscopy and related expenses from December 9, 2013, under your plan's Medical Benefits provision, subject to any applicable deductible/coinsurance amounts. Additional benefits are not available.

Director's Review

The federal Patient Protection and Affordable Care Act requires health plans and health insurers offering group or individual health insurance coverage to provide benefits for certain preventive care services without imposing cost sharing. See 42 USC § 300gg-13 and regulations at 45 CFR §147.130.

Among the required preventive care benefits are those recommended by the United States Preventive Services Task Force and include "screening for colorectal cancer." The Task Force recommends screening for colorectal cancer for adults beginning at age 50 using fecal occult blood testing, sigmoidoscopy, or colonoscopy. The Petitioner's preventive care benefits are described in the certificate (p. 22).

Generally, preventive care focuses on evaluating current health status when there are no symptoms. However, if medical treatment is sought for a specific health condition or symptom, or a test or procedure is needed to manage a known condition, those services may be considered to be diagnostic (not preventive) and subject to cost sharing.

The question of whether the Petitioner's colonoscopy was preventive care was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the PRIRA, MCL 550.1911(6). The IRO physician reviewer is certified by the American Board of Internal Medicine with a subspecialty in gastroenterology; is published in the peer reviewed medical literature; and is in active practice. The IRO report included the following analysis and recommendation:

Reviewer's Decision and Principal Reasons for the Decision:

It is the determination of this reviewer that the colonoscopy performed on December 9, 2013 was considered to be preventative care.

Clinical Rationale for the Decision:

The American Gastroenterological Association (AGA) in their 2012 position paper recommends screening colonoscopies done every five to ten years after the removal of one to two small tubular adenomas. The position paper specifically

terms this as “surveillance and screening.” The Agency for Healthcare Research and Quality (AHRQ) concurs exactly with this recommendation. Therefore the preventive service continues to be provided, only at a more accelerated rate.

The United States Department of Health and Human Services website specifically notes under preventative screening for colon cancer as follows: “If you are age 50 to 75, get tested regularly for colorectal . . . cancer. All it takes is a visit to the doctor to have a special exam (called a screening).”

Testing regularly with preventative examinations is the basis of colorectal cancer screening. As such for this enrollee, the only issue is the interval of the screening. Otherwise, according to the logic of the denial, the enrollee is prohibited from preventive screening for the rest of his life based on the discovery of a colon polyp. This is not the tone and message of the government website or the understanding of common practice or the current medical literature.

Preventive care is defined as “a pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.”

The enrollee was completely asymptomatic and presented for routine preventative screening. The colonoscopy performed on December 9, 2013 is considered to be preventative care. To opine otherwise would determine that the enrollee would never have preventative colonoscopies again for the rest of his life given the history of polyps. This is not the understanding of a preventative procedure. The enrollee is at a higher than average risk for colon polyps, but since he is asymptomatic, the procedure was preventative in nature. The definition of preventative care is to screen asymptomatic patients for the presence of disease. This enrollee is at a higher-than-average risk for polyps; however, he may never have another polyp in his life. The enrollee is simply undergoing routine preventative screening at an accelerated rate of five years after his last colonoscopy rather than waiting a decade. For the reasons noted above, the colonoscopy in question is considered preventative care.

Recommendation:

It is the recommendation of this reviewer that the denial issued by Golden Rule Insurance Company for the colonoscopy on December 9, 2013 be overturned.
[References omitted.]

The Director is not required to accept the IRO’s recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite “the principal reason or reasons why the [Director] did not follow the assigned

independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's recommendation is based on experience, expertise, and professional judgment. Furthermore, it is not contrary to any provision of the Petitioner's certificate of coverage.

The Director, discerning no reason why the IRO's recommendation should be rejected in this case, finds that the colonoscopy the Petitioner received on December 9, 2013, was a preventive procedure not subject to cost sharing requirements.

V. ORDER

The Director reverses Golden Rule's July 16, 2015, final adverse determination. Golden Rule Insurance Company shall immediately cover the Petitioner's colonoscopy as a preventive care service with no cost-sharing. Golden Rule shall, within seven days of providing coverage, furnish the Director with proof that it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, at this toll free telephone number: (877) 999-6442.

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