

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. 146497-001

HealthPlus Insurance Company  
Respondent

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Issued and entered  
this 20<sup>th</sup> day of March 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On February 25, 2015, ██████████, on behalf of his brother ██████████ (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.*

The Petitioner receives health care benefits under an individual plan underwritten by HealthPlus Insurance Company. The Petitioner's health care benefits are defined in the HealthPlus *Signature PPO Individual Certificate of Coverage*.

The Director notified HealthPlus of the external review request and asked for the information it used to make its adverse determination. After a preliminary review of the material received, the Director accepted the case on March 4, 2015.

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 was scheduled for a colonoscopy on October 17, 2014. After the anesthesia was administered the Petitioner began experiencing premature ventricular contractions (an abnormal heartbeat). The procedure was aborted and the Petitioner was told to go to the emergency room of ██████████ Hospital in ██████████. The Petitioner was treated and released the same day. He had follow-up medical tests on November 7 and 14 at ██████████ Hospital.

██████████ billed \$3,130.43 for the emergency treatment and charged \$198.00 for the November 7 services and \$150.77 for the November 14 services. HealthPlus approved the claims but assessed the Petitioner deductible charges of \$3,064.60 for the October 17 services, \$26.69 for the November 7 services and \$153.37 for the November 14 services.

The Petitioner appealed the benefit decisions through the HealthPlus internal grievance process. At the conclusion of that process, HealthPlus issued a final adverse determination dated January 8, 2015 and a follow-up letter dated February 4, 2015 affirming its claims processing decisions. The Petitioner now seeks the Director's review of HealthPlus's decisions.

### III. ISSUE

Did HealthPlus correctly process the Petitioner's claims for the treatment he received from ██████████ Hospital on October 17, November 7 and November 14, 2014?

### IV. ANALYSIS

#### Respondent's Argument

In its January 8, 2015 final adverse determination, HealthPlus wrote that its claims processing was reviewed by their director of customer service:

She has determined that the claim(s) processed correctly according to the terms of your Schedule of Benefits (SOB) and Certificate of Coverage (COC).

Her decision is supported in the enclosed SOB; under Emergency Health Services, which states that the member is responsible for 30% after the deductible has been met. Our records indicate that you[r] deductible is \$5,000.00 per member and \$10,000.00 per family for all in-network services. According to our claims system you did not meet your deductible prior to services being rendered on October 17, 2014, therefore you are financially responsible for services rendered to you by ██████████ Health System.

You indicate in your letter that the emergency room (ER) visit was initiated while attempting to have a colonoscopy. While we understand that the physician's recommendations may have been inconvenient, we rely on the treating physicians to manage and direct our members care. Records indicate that services were rendered to you at ██████████ Health System. We recommend that you contact ██████████ Health System directly to arrange a payment plan.

In its February 4, 2015 letter, HealthPlus wrote:

We recognize and appreciate the circumstances that led to your ER visit; however, the fact remains services were rendered in the ER, regardless of how or why you came to arrive there. As such, claims were processed according to your ER benefit as outlined in your Schedule of Benefits (SOB). We are required to process claims based on the information submitted.

Petitioner’s Argument

In a letter dated February 20, 2015, submitted with his request for external review, the Petitioner wrote:

The charges under dispute and appeal below relate to a colonoscopy which is covered as a preventive procedure under my policy and approved by [REDACTED], my primary care physician.

Due to the complications of other patients scheduled prior to my visit, my procedure schedule for 12:15 p.m. did not begin on schedule. This basically put me in a precarious position which was well over a 24 hour period of preparation for this procedure without food.

The procedure was aborted after insertion of the anesthesia where premature ventricular contractions (PVC’s) began to occur. [REDACTED] of Gastrointestinal Endoscopy Center cancelled the procedure before it began and approved that my brother...take me to the [REDACTED] Hospital, [REDACTED] Emergency to address the PVC’s.

Based on the services rendered relating to my colonoscopy on this day, there are charges which occurred during and after the event which HealthPlus determined should be applied to my deductible.

\* \* \*

I disagree and contend that HealthPlus should absorb the cost of these services as preventive since 100% of these costs relate to the colonoscopy and advisement by [REDACTED] [REDACTED] who is a provider under [HealthPlus].

The colonoscopy and subsequent related costs as instructed by [REDACTED] were “Preventative” and included service under the HealthPlus Certificate of Coverage Section VIII – Schedule of Covered Services paragraph 8.1 Immunizations and Preventive Services, part E. Colorectal Cancer Screenings beginning at age fifty (50) Colonoscopy – once every 10 years.

My health record shows a patient that has performed his due diligence in seeing doctors to maintain health. This procedure was expected to be a 100% covered cost....

\* \* \*

It is my position that especially the emergency room cost and the post preventive doctor visit costs billed to review the PVC’s should be borne by HealthPlus as a covered preventive benefit under my plan.

Director’s Review

The Schedule of Benefits for the Petitioner’s *Signature PPO* certificate of coverage provides the details of the certificate’s cost sharing requirements:

All Covered Services except preventive services are subject to the Deductible. You are responsible for paying the Deductible before HealthPlus Insurance will start to pay benefits for those Covered Services. After the Deductible is met, you are responsible for the

Member percent Coinsurance until the Out-of-Pocket Maximum is met. Flat dollar copays for all covered services also apply to the Out of Pocket Maximum.

There are no cost sharing requirements for preventive services.

On October 17, 2014 the Petitioner was treated in the emergency department of [REDACTED] Hospital and received follow-up care there in November. Because the Petitioner had not satisfied the deductible prior to receiving those services, he was financially responsible for a significant deductible.

The Petitioner argues that his emergency treatment and the follow-up care were related to his cancelled colonoscopy, a preventive service with no deductible requirement. The Petitioner believes that, because they were related to the colonoscopy, the emergency treatment and follow-up care should also be exempt from the deductible requirement.

The emergency services the Petitioner received on October 17, 2014 and the subsequent medical services he received on November 7 and 14, 2014, were not themselves preventive services. Insurance benefits for medical services are determined by the nature of the services themselves and not on the basis of their relationship to other treatment.

HealthPlus processed the Petitioner's claims correctly according to the nature of the services provided and the requirements of the *Signature PPO* certificate of coverage.

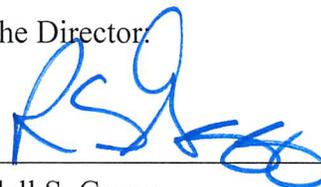
#### V. ORDER

The Director upholds HealthPlus Insurance Company's February 4, 2015, 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.

Annette E. Flood  
Director

For the Director.



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Randall S. Gregg  
Special Deputy Director