

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. 147317-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 6th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 14, 2015, ██████████ (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.* On April 21, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through an individual plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on April 29, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. MCL 550.1911(7).

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the *Blue Cross Premier Bronze Benefits Certificate*¹ (the certificate).

¹ BCBSM form no. 602F, federal approval 09/13, state approval 08/14.

On December 4, 2014, the Petitioner had a preventive care office visit with her physician for which BCBSM paid 100% of its approved amount. The Petitioner also had a number of laboratory tests related to the office visit and in nearly every case BCBSM applied its approved amount for each test to the Petitioner's deductible for in-network services, leaving her responsible out-of-pocket for \$201.59.

The Petitioner appealed BCBSM's claims processing decisions through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 18, 2015, affirming decisions. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claims related to the Petitioner's December 4, 2014, office visit?

IV. ANALYSIS

Petitioner's Argument

On the external review request form the Petitioner wrote:

In December 2014, I was notified by a BCBS member that I had a complementary wellness exam with my PCP [*primary care physician*]. I went to that exam and received an EKG [*electrocardiogram*] which is protocol for my doctor to do with a wellness exam. This was my first and only EKG and my doctor said I needed a baseline.

The CBC [*complete blood count*] and U/A [*urine analysis*] have always been a part of my wellness exams. Therefore, I request they be paid for as previously done as part of my wellness exam.

BCBSM's Argument

In its final adverse determination, BCBSM wrote:

You are covered under the *Blue Cross Premium Bronze Benefits Certificate (Certificate)*. According to Pages 91 through 93 of the *Certificate*, we pay 100 percent of our approved amount for these preventive care services: Health Maintenance Examination, Flexible Sigmoidoscopy, Gynecological Examination, Screening Mammography, Fecal Occult Blood Screening. We also pay for the following screening services: Well-Baby and Child Care Visits, Immunizations, Chemical profile and cholesterol testing services, Colonoscopy, Morbid Obesity

Weight Management, Tobacco Cessation Programs, and Women's' Preventive Care Contraceptive Services.

Specifically Page 93 notes, "We do not pay for screening services other than the ones listed above." Because the laboratory services were reported with a routine screening diagnosis, but are not included on the list of payable screening services for your plan, no payment is available and you remain responsible for the non-covered charges. . . .

On December 4, 2014, you received several laboratory services for which payment was approved, and applied to your deductible requirement.

- Vitamin dm 25 hydroxy, includes fraction[s], if performed (Procedure code 82306)
- Microsomal antibodies [e.g. Thyroid or liver-kidney] each (Procedure code 86376)
- Thyroglobulin antibody (Procedure code 86800)
- Collection of venous blood by venipuncture (Procedure code 36415)
- Triiodothyronine T3; free (Procedure code 84481)
- Lipid Panel (Procedure code 80061)
- Thyroid stimulating hormone (Procedure code 84443)
- Cyanocobalamin [vitamin b-12] (Procedure code 82607)
- Folio Acid; serum (Procedure code 82746)
- Hemoglobin; glycosylated (ale) (Procedure code 83036)
- Lactate dehydrogenase (Procedure code 83615)
- Glutamyltransferase, (ggt) (Procedure code 82977)
- Thyroxine; total (Procedure code 84436)
- Iron (Procedure code 83540)
- Uric acid, blood (Procedure code 84550)
- Hepatitis panel (Procedure code 80076)
- Electrolyte panel (Procedure code 80051)
- Urea nitrogen, quantitative (Procedure code 84520)
- Calcium, total (Procedure code 82310)
- Creatinine; blood (Procedure code 82565)

These tests were reported with medical/diagnostic codes (244.9 - unspecified hypothyroidism, 790.29 - other abnormal glucose, 280.9 - iron deficiency anemia, unspecified). Page 34 of the certificate explains that diagnostic services (including diagnostic laboratory and pathology services) are payable when needed to diagnose a disease, illness, pregnancy or injury. Further, page 14 of your certificate explains your financial responsibility for these services in Section 2: What You Must Pay:

Deductible for In-Network Outpatient Services, Emergency Room Services, and Prescription Drugs

You are required to pay the following deductible each calendar year for all covered Outpatient facility and professional services, all Emergency facility and professional services and all retail and mail order pharmacy drug services provided by in-network providers:

- \$6,350 for one member
- \$12,700 for the family

Our records show that your in-network deductible had not been met at the time these claims processed. Thus, the deductible was appropriately applied to the above services. You remain liable for the deductible amount of \$162.94 for the covered diagnostic laboratory services you received.

I understand that you feel as though you should have no remaining financial liability for these claims because you believe they should be included as part of the Health Maintenance Exam you received the same day. This exam and the payable routine screening services you received did pay at 100 percent of our approved amount. However, the EKG, complete blood count and urinalysis you received are not payable with a routine diagnosis. Furthermore, the other laboratory services you received were reported as diagnostic services and must process according to your cost share requirements.

Director's Review

The Petitioner believes that she should not have any cost sharing for the laboratory tests she had as part of her annual "health maintenance examination" (certificate, p. 91).

The federal Patient Protection and Affordable Care Act requires health plans and insurers to cover without cost sharing those preventive care services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);² the certificate (pp. 91-93) lists the preventive care services that BCBSM says are covered with no deductible, coinsurance, or copayment when performed by an in-network provider.

² See 42 USC § 300gg-13 and regulations at 45 CFR §147.130.

BCBSM paid 100% of its approved amount for the preventive office visit and for two of the tests: the cervical or vaginal screening cytopathology (CPT code G0145) and HPV detection (CPT code 87621). The balance of the tests the Petitioner received are not included in list of preventive care services with an A or B rating from the USPSTF, nor are they listed in the certificate as services that are not subject to cost sharing. Therefore, they are not exempt from the certificate's cost sharing provisions and are subject to the deductible for in-network outpatient services (certificate, p. 14).

The Director concludes that BCBSM correctly processed the claims for the services the Petitioner received on December 4, 2014.

V. ORDER

The Director upholds BCBSM's final adverse determination of February 18, 2015.

This is a final decision of an administrative agency. 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. See MCL 550.1915(1). 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:



Randall S. Gregg
Special Deputy Director