

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

[REDACTED]

Petitioner,

v

File No. 149624-001

Blue Cross Blue Shield of Michigan,

Respondent,

Issued and entered
this 22nd day of September 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

[REDACTED] (Petitioner) thought that his health plan had incorrectly processed the claims related to polysomnography services he received. On August 31, 2015, he filed a request with the Director of Insurance and Financial Services for an external review of the plan's claim processing decisions 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 September 8, 2015.

The Petitioner, a resident of [REDACTED] receives health care coverage through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. BCBSM provided its response on September 10, 2015.

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 BCBSM's *Simply Blue HRA Group Benefits Certificate LG* (the certificate). *Rider SB-HRA-D-IN \$4000/\$8000 LG Simply Blue HRA*

Deductible Requirement for In-Network Services (the rider) amends the certificate to increase the annual deductible for in-network services.

The Petitioner received polysomnography services in May 2015 from in-network providers. Believing that the claims for those services had not been correctly processed, he appealed through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated August 12, 2015, affirming its decisions. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claims for the Petitioner's sleep studies?

IV. ANALYSIS

The Petitioner received these sleep study services:

- On May 4, 2015, he had a polysomnography (i.e., a sleep study) performed at [REDACTED] BCBSM's approved amount for the test was \$677.13 and it applied that amount to the Petitioner's annual deductible for in-network services.
- On May 14, 2015, he had second, different polysomnography, one that included the use of a continuous positive airway pressure (CPAP) device.² This test was performed by [REDACTED] BCBSM initially processed the claim for the test in error but eventually reprocessed it and paid [REDACTED] \$459.88, its full approved amount for the service.³ The Petitioner had no out-of-pocket expense for the test.
- On May 29, 2015, [REDACTED] submitted a claim for a May 20, 2015, date of service using CPT code 95811. BCBSM said this charge was for the "reading and interpreting the study results [*of the May 14 polysomnography*]." BCBSM applied its approved amount for the service, \$140.58, to the Petitioner's in-network deductible.

The Petitioner's total out-of-pocket expense for the sleep study services from [REDACTED] was \$817.71 (\$677.13 for the May 4 polysomnography and \$140.58 for the May 20 interpretation).

1 Billed as CPT code 95810, "sleep staging with 4 or more additional parameters of sleep, attended by a technologist." *Current Procedural Terminology*, 2012 Professional Edition.

2 Billed as CPT code 95811, "sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist." *Current Procedural Terminology*, 2012 Professional Edition.

3 According to BCBSM, this polysomnography is paid at 100% of the approved amount when the claim is submitted with diagnosis code 786.09. In contrast, the claims for the sleep study services performed by [REDACTED] were submitted with diagnosis code 327.21.

On the external review request form the Petitioner described his complaint:

Please relieve me of the bills that were duplicated and sent to me for services that were not actually rendered on the said date (May 20) and also for any duplicative charges charged by the institutes.

While he did not identify any duplicative charges or services, the Petitioner did specifically object to the May 20 charge from [REDACTED] for [REDACTED] services. It is the Petitioner's contention that [REDACTED] could not bill for a May 20 reading and interpretation of the May 14 polysomnography because he had already done it on May 15 when he prescribed a CPAP machine for the Petitioner. In a letter dated August 25, 2015, included with external review request, the Petitioner argued:

1. The doctor has given a prescription on 5/15/15 which clearly indicates that [REDACTED] has done the needed reading/interpretation of the study results. Do you believe that the doctor has given a prescription without doing a study / interpretation?
2. The doctor has clearly stated on the prescription and signed that he is sending a copy of the NPSG and CPAP titration study on 5/15/15.
3. I still fail to understand what reading / interpretation was done on May 20, 2015. Going by the date and sign of the doctor it clearly indicates that everything has been done by May the 15th.

It is presumably the Petitioner's position that the charge for reading and interpreting the May 14 polysomnography should be included in the charge for the polysomnography itself. However, in its final adverse determination, BCBSM's representative explained to the Petitioner:

To give your appeal all possible consideration, I reached out to the providers of your sleep study services. I have verified with both [REDACTED] and [REDACTED] that the charges billed by [REDACTED] were for services performed by [REDACTED] [REDACTED] is affiliated with the [REDACTED]. In addition, I have verified that the services performed by [REDACTED] are separate services, and it is appropriate to bill them as such.

I have also verified with [REDACTED] that the date of May 20, 2015 was the appropriate billing date for procedure code 95811. . . . The provider confirmed this charge is for the doctor reading and interpreting the study results, and was not a date that you were present at an office visit.

The certificate (p. 33) covers diagnostic services such as polysomnography. The certificate (p. 10) also makes clear that the in-network deductible will be imposed on diagnostic services. Therefore, the Director concludes that BCBSM correctly applied its approved amount

for the sleep study services of [REDACTED] Clinic to the Petitioner's annual \$4,000.00 deductible. The rider establishes the annual deductible for in-network services at \$4,000.00 for an individual; there was no showing in the record that the deductible had been met at the time the services were rendered.

Regarding the Petitioner's implicit argument that [REDACTED] [REDACTED] could not bill separately for the reading and interpretation of the May 14 polysomnography, the Director finds nothing in the certificate to support that contention. As BCBSM points out, the polysomnography services were performed by two providers and each was entitled to submit a claim.

The Director also rejects the Petitioner's argument that [REDACTED] could not bill for the reading and interpretation using May 20, 2015, as the date of service because he had already done the work five days earlier when he presumably used the test results as the basis for prescribing a CPAP device for the Petitioner. The Director finds that the date of the claim is immaterial in this case. The important point is that [REDACTED] was entitled to submit a claim for his services and he submitted only one; he did not bill twice for the service.

After reviewing the entire record the Director concludes that BCBSM correctly processed the claims for the Petitioner's sleep study services.

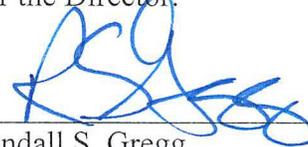
V. ORDER

The Director upholds BCBSM's August 12, 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 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