

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. 153450-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 2nd day of June 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage for laboratory and pathology services by his health insurer, Blue Cross Blue Shield of Michigan (BCBSM).

On April 28, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On May 5, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a group plan that is underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM responded on May 13, 2016.

The case involves a medical issue so it was assigned to an independent review organization which submitted its recommendation to the Director on May 19, 2016.

II. FACTUAL BACKGROUND

At the time the Petitioner received the services at issue in this case, his health care benefits were described in BCBSM's *Simply Blue Health Savings Account Without Prescription Drug Coverage Group Benefits Certificate* (the certificate).¹

On June 6, 2014, the Petitioner had genetic testing for mutations associated with limb girdle muscular dystrophy. BCBSM denied coverage on the basis that the testing was not medically necessary. The charge for the testing was \$14,950.00.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 4, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Was BCBSM correct when it denied coverage for the Petitioner's genetic tests?

IV. ANALYSIS

Respondents' Argument

In its final adverse determination, BCBSM explained its decision to the Petitioner:

. . . According to [the certificate's] Page 4.13 of **Section 4: Coverage for Physician and Other Professional Provider Services**, diagnostic laboratory services are payable to diagnose a disease, illness, pregnancy or injury. However, all benefits are subject to limitations.

The Blue Cross Blue Shield Association (BCBSA) Medical Policy "*Mutation Testing for Limb-Girdle Muscular Dystrophies*" states:

Genetic testing for mutations associated with limb-girdle muscular dystrophy (LGMD) may be considered medically necessary when at least one of the following criteria are met:

- Results of testing may lead to changes in clinical management that improve outcomes (e.g., confirming or excluding the need for cardiac surveillance); OR
- Genetic testing will allow the affected patient to avoid invasive testing, including muscle biopsy.

To ensure full consideration was given to your appeal, an associate

¹ BCBSM form no. 665C, approved 10/12.

medical director, board-certified M.D. in Internal Medicine reviewed your medical records, your claim, your appeal, and your health care plan benefits for BCBSM. The physician determined that:

The adult member had been diagnosed with limb girdle muscular dystrophy many years ago with clinical analysis, muscle biopsy and lab tests. Management of his condition has been well documented. According to BCBSA medical policy "*Mutation Testing for Limb-Girdle Muscular Dystrophies*," criteria for testing has not been met. Specifically, a diagnosis has been made and the results of the genetic testing will not lead to a change in management that affects health outcomes.

Petitioner's Argument

In a letter dated April 4, 2016, that was submitted with his external review request, the Petitioner wrote:

On the March 4th, 2016 in the denial from BCBSM . . . I was informed that the services could not be paid because I did not meet the criteria for genetic testing for Muscular Dystrophy. It was stated that I had been diagnosed with limb girdle muscular dystrophy "many years ago" with clinical analysis. I was preliminary diagnosed with Muscular Dystrophy back in 1986 at Henry Ford Hospital where I had a clinical analysis and a muscle biopsy performed and the results came back consistent with Muscular Dystrophy. As a result of this preliminary diagnosis I sought care with Dr. [REDACTED] in 2012 and he continued treatment of my symptoms. As time passed my health continued to decline and in 2013 with consultation among my care team Dr. Green decided it was time I be sent for further DNA testing; to confirm this DX and design a confirmed treatment plan. Unfortunately, these lab tests (6/2/2014) did confirm what Dr. [REDACTED] was suspecting . . . I now have a confirmed case of Limb Girdle Muscular Dystrophy.

I am a very sick man, please see the clinical documentation from my doctors stating that I have had troubles with extremity weakness progression, elevated CPK results, increased falls, severe sleep apnea, among other health declines over the many years . . . please understand that I am a patient who is looking for guidance and the best treatment from my care team of doctors. These tests were ordered to do such that - narrow down a diagnosis and begin an intense confirmed treatment plan of my illness.

Director's Review

The certificate covers diagnostic laboratory and pathology services (p. 4.13). However, a service must be medically necessary to be covered (p. 7.15). "Medical necessity" is defined (p.

7.16) as “[h]ealth care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. . . .”

The question of whether Petitioner’s June 2, 2014, diagnostic laboratory services were medically necessary for the treatment of his condition was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the Patient’s Right to Independent Review Act, MCL 550.1911(6).

The IRO physician reviewer is board certified in neurology, is in active clinical practice, and is familiar with the medical management of patients with the member’s condition. The IRO report included the following recommendation and analysis:

Recommended Decision:

The MAXIMUS physician consultant determined that the laboratory and pathology services performed on 6/2/14 were not medically necessary for diagnosis and treatment of the member’s condition.

Rationale:

* * *

The member was recently seen by a physician, who ordered genetic testing. . . . The MAXIMUS physician consultant explained that there is no current standard of care for genetic testing for the group of limb girdle muscular dystrophies since treatment is not available. The Health Plan’s criteria require that for genetic testing to be covered, the results must lead to a potential different outcome with clinical treatment. The physician consultant explained that since there are no current treatment options for these forms of muscular dystrophy, the criteria for coverage were not met.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the laboratory and pathology services performed on 6/2/14 were not medically necessary for diagnosis and treatment of the member’s condition. [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 analysis is based on extensive experience, expertise, and professional judgment. In addition, the IRO’s recommendation is not contrary to any provision of the Petitioner’s certificate of coverage. MCL 550.1911(15).

The Director, discerning no reason why the IRO's recommendation should be rejected in this case, finds that the June 2, 2014, laboratory and pathology services were not medically necessary for the treatment of the Petitioner's condition and are therefore not a benefit under the terms of the certificate.

V. ORDER

The Director upholds BCBSM's March 4, 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:

A handwritten signature in black ink, appearing to read 'R. S. Gregg', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director