

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. 153663-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 20th day of June 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) receives health care benefits through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Petitioner is dissatisfied with the way BCBSM processed a claim for a mammogram.

On May 12, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the information submitted, the Director accepted the request on May 19, 2016.

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 26, 2016.

Initially, this case appeared to involve only contractual issues. Later, it was determined that medical issues were involved so the Director assigned it to an independent medical organization, which provided its analysis and recommendation to the Director on June 20, 2016.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are described in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs LG* (the certificate).

The Petitioner had a routine, preventive mammogram on February 18, 2016, from an in-network provider. The facility that performed the mammogram asked the Petitioner to return for a second mammogram on February 19, 2016.

BCBSM covered the first mammogram as a preventive service with no cost sharing (i.e., deductibles or coinsurance) by the Petitioner but it applied its approved amount for the second mammogram (\$562.00) to her annual deductible.

The Petitioner appealed BCBSM's decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated April 22, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is BCBSM correctly process the claim for the second mammogram?

IV. ANALYSIS

Petitioner's Argument

In the external review request, the Petitioner wrote:

I had a routine mammogram on 2/18. Within a few hrs of that test, I got a call from [the provider] asking me to come back for a repeat mammogram as they could not see pictures clearly from my first mammogram.

BCBSM is denying my claim and is applying the second mammogram cost (\$562) to my deductible. Why should I have to pay deductible because the first test did not pick up images clearly? I want BCBSM to pay for mammogram which doctors asked for second time.

BCBSM's Argument

In the final adverse determination BCBSM explained its position to the Petitioner:

. . . After review, I confirmed that the claim processed correctly according to your contract. The service was reported as a diagnostic mammogram. Diagnostic mammography services are subject to your contractual cost-

sharing requirements. We only pay for one routine screening mammogram for each member, each year. Our records indicate that we paid for a routine screening mammogram . . . on February 18, 2016. You remain responsible for the in-network deductible totaling \$562.00.

* * *

Page 96 of the *Certificate* says that we pay for facility and physician diagnostic radiology services, including medically necessary mammography, subject to your cost sharing requirements. The services provided on February 19, 2016 were reported as medically necessary mammography services. As a result, payment for procedure code G0206 (diagnostic mammogram) and 77051 (computer-aided detection digital) was subject to the cost-sharing requirement of your plan.

Our records reflect that, prior to the charges that accrued on this date of service, your family in-network deductible (\$2,600) had not been met. Therefore, BCBSM correctly applied 100 percent of our approved amount to your in-network family deductible.

In your appeal letter and during the managerial-level conference, you said that you were asked by your doctor to return for additional mammography testing. The mammogram on February 19, 2016, was reported as a diagnostic mammogram. BCBSM must process the claims as they are submitted and in accordance to your group's health care benefits. As a result, I am unable to grant your request.

Director's Review

The certificate (p. 85) says that the plan will cover

one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. You will not have to pay your cost-sharing if this service is done by an in-network provider.

Medically necessary diagnostic mammograms are also covered under the certificate (p. 96) but they are subject to the deductible and copayment provisions in the certificate (p. 9).

The Petitioner contends that the second mammogram was needed because the first one was not readable, that it was a repeat of the first. She argues that BCBSM must therefore also cover it with no cost sharing. BCBSM contends that the second mammogram was diagnostic in nature and thus subject to the annual deductible.

To answer the question of whether the second mammogram was a routine or a

diagnostic service, the Director assigned the case to an independent review organization as required by section 11(6) of the Patient's Right to Independent review Act, MCL 550.1911(6).

The IRO physician reviewer is certified by the American Board of Radiology with added qualifications in vascular and interventional radiology; is medical director of an outpatient imaging system with a special interest in mammography and breast interventions; is published in peer reviewed literature; is familiar with the medical management of patients with the Petitioner's condition; and is in active clinical practice. The IRO report included the following analysis and recommendation:

Reviewer's Decision and Principal Reasons for the Decision:

Is the diagnosis code for the second mammogram incorrect given the circumstances of this case?

No. It is the determination of this reviewer that the diagnosis code is correct.

Was there technical error or mechanical problem in the first mammogram that required a second mammogram?

No. It is the determination of this reviewer that the first mammogram was diagnostic quality.

Was the second mammogram necessitated by something revealed by the first mammogram?

Yes. It is the determination of this reviewer that the second mammogram was in direct response to an abnormality detected in the first screening mammogram.

Was the repeat second mammogram a preventive or diagnostic service?

It is the determination of this reviewer that the repeat second mammogram was a diagnostic service, not a preventative service.

Clinical Rationale for the Decision:

The American College of Radiology (ACR) Mammogram Guidelines and Practice Parameter are specific that a diagnostic mammogram is ordered for evaluation of a finding detected on a screening mammogram (See Section II, B, 2 on page 3). This reference details exactly what to do when an abnormal finding is identified on a screening mammogram, which is the standard of care. The American Cancer Society (ACS) mammogram publication for patients describes the differences between a BI-RADS 0

and 1 (incomplete and negative). A Medscape breast cancer breast workup outlines the process of obtaining a screening mammogram and subsequent diagnostic examination.

The ACR Practice Parameter specifically identifies this enrollee's circumstance. From a mammography standpoint, the enrollee is a healthy female undergoing standard annual screening mammography. She was found to have a common cause for call-back, an asymmetric density in the breast. The enrollee received an appropriate diagnostic code, was called for a diagnostic work-up of a mammographic abnormality, which was found to be due to overlapping of her heterogeneously dense breast tissue.

The standard of care for screening mammography and subsequent diagnostic workup of a suspicious lesion was followed for this enrollee. The initial screening mammogram was not only of diagnostic quality, but it revealed a potential breast cancer asymmetric density, for which the additional diagnostic workup was performed. The second mammogram was a diagnostic examination, not a standard four view screening mammogram. It was a single breast targeted mammogram with images in the true lateral plane plus additional spot compression images specifically targeting the area of focal density to see if there was an underlying cancer or other lesion. Therefore, based on the documentation submitted for review, current practice parameters and medical literature, the second mammogram was a diagnostic procedure, not a preventive service.

Recommendation:

It is the recommendation of this reviewer that the denial issued by Blue Cross and Blue Shield of Michigan for the second mammogram be upheld.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the IRO's 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 analysis is based on extensive experience, expertise, and professional judgement. In addition, the IRO's recommendation is not contrary to any provision of the Petitioner's coverage. MCL 550.1911(15). The Director, discerning no reason why the IRO's recommendation should be rejected, adopts the recommendation and finds that the second mammogram was a diagnostic and not preventative procedure and

therefore subject to the deductible.

V. ORDER

The Director upholds BCBSM's final adverse determination of April 22, 2016.

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