

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 112320-001

v

Midwest Security Life Insurance Company
Respondent

Issued and entered
this 4th day of January 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 17, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

Midwest Security Life Insurance Company (Midwest), Petitioner's insurer, was notified of the petition and requested to provide the information used in making its adverse determination. The information was received June 18, 2010, and the Petitioner's request for review was accepted on June 24, 2010.

This review can be decided by applying the terms of the contract defining the Petitioner's health care benefits. Petitioner is covered under Midwest's "Mid Michigan Child Care MI 42847" group insurance certificate. The Commissioner 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

On October 26, 2009, Petitioner went to the XXXXX Family Medical Center in XXXXX, Michigan for a routine examination by her physician who ordered several lab tests. Upon completion of the exam, Petitioner proceeded directly to the laboratory located in the same building. A claim for the lab work was later filed with Midwest by XXXXX Hospital in XXXXX.

Midwest initially classified all the lab work as subject to Petitioner's \$1,000.00 calendar year deductible. Following the Petitioner's appeal in Midwest's internal grievance system, Midwest provided coverage for procedures 36415, 80061, 85025 and 88175 as "routine" services payable at 100% (i.e., without deductible) but processed procedures 80053, 82550, 86038, 86225, 86235, 86431 and 85651 as diagnostic services payable as outpatient hospital services and therefore subject to the \$1,000.00 deductible.

Midwest's final adverse determination was issued April 16, 2010.

III ISSUE

Did Midwest properly process the October 26, 2009, claim for lab work under the certificate?

IV ANALYSIS

Petitioner's Argument

Petitioner maintains that neither the exam nor the lab work was performed at XXXXX Hospital. In addition, all services were related to a routine doctor visit. For these reasons, the Petitioner believes that all of the lab work should be covered under the benefit provision which provides 100% coverage after satisfying the \$25 copayment.

Respondent's Argument

In its April 16, 2010, final adverse determination, Midwest gave the following rationale for their handling of the lab tests:

This claim was billed with the place of service being an outpatient laboratory in a hospital. Your plan offers laboratory charges that are not done on the same date of an office visit and at the *same place as the office visit* as being subject to your deductible and co-insurance. This is stated in your Certificate of Health Insurance under the Physician/Clinic Other Services and Physician visits section of your schedule of benefits.

Therefore, these lab charges 80053, 82550, 86038, 86225, 86235, 86431, 85651 were applied to your deductible correctly and will not be reconsidered for additional payment.

The lab charges for 36415, 80061, 85025 and 88175 are being reprocessed under your Routine Benefit.

Commissioner’s Review

Coverage for laboratory tests is described on page 13 and 14 of the policy:

Other medical and surgical expenses which may qualify as covered expenses under the Policy shall include:

* * *

(7) Charges which are made by a Hospital, independent Physician, or by a licensed medical technician who is qualified to do so and which are for . . . (d) laboratory tests; or (e) for such other analysis as may be made for diagnostic or treatment purposes such as for associated radiology and pathology. . . .

The policy’s Schedule of Benefits describes two types of coverage which include lab services: “physician visits” and “physician/clinic other services.” These portions of the Schedule of Benefits are reproduced below:

| Types of Coverages | Network | Non-Network |
|---|--|-------------------------------------|
| PHYSICIAN VISITS Includes office/clinic diagnostic x-ray & lab services, if part of office visit, on same date of office visit and at same place of office visit. | 100% after each \$25 copayment per visit | 70% of UCR charges after deductible |
| PHYSICIAN/CLINIC OTHER SERVICES Including durable medical equipment, home health care, hospital visits, inpatient & outpatient diagnostic x-ray & lab, and other physician services. | 100% after deductible | 70% of UCR charges after deductible |

In-Network Lab services provided on the same date and in the same place as a physician visit are not subject to a deductible charge. Lab services classified as “physician/clinic other services” do require the insured to pay a deductible. The Petitioner and Midwest are in agreement that the lab services were ordered as part of a physician visit. The lab services were billed for the

same date as the physician visit. The parties are not in agreement as to whether the lab services were “at the same place of office visit.” However, the billing for the lab services came from XXXXX Hospital, the medical provider that performed the services. The Petitioner’s physician office visit was not at XXXXX, so it must be concluded that the lab services were not performed at the same place as the office visit even though the location where blood was drawn may have been located in the same building.

Midwest processed four of the lab tests under the “no deductible” coverage provision while seven other tests were processed under the provision which does require a deductible. Why the lab services were divided in this way when all the lab services were provided on the same date and by the same laboratory was not explained by Midwest. Nevertheless, the effect of this division of the lab test works in the Petitioner’s favor by lessening the deductible charged, and will not be reversed in this order.

The Commissioner finds that Midwest processed the claim in a manner that is consistent with the terms of the certificate of coverage when it applied a deductible to the October 26, 2009, lab services.

**V
ORDER**

The Commissioner upholds Midwest Security’s April 16, 2010, 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 sixty 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross
Commissioner

