

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. 147548-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 17th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 27, 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 May 4, 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 May 12, 2015.

The issue in this external review can be decided by a contractual analysis. 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 *Keep Fit And Member Edge Individual Market Certificate*¹ (the certificate). *Rider IOC \$5,000/\$10,000-I, \$8,500/ \$17,000-O, \$8,500/\$17,000 OOPM* (the rider) amends the certificate "by imposing separate annual deductible requirements on covered inpatient and outpatient facility and professional services

¹ BCBSM form no. 351D, approved 05/14.

performed by panel and nonpanel providers and by increasing the annual coinsurance maximums applicable to panel and nonpanel inpatient services.”

On November 5, 2014, the Petitioner had her annual physical examination and her physician ordered certain laboratory tests. The tests were performed on November 21, 2014, by a network (i.e., panel) provider. BCBSM covered most of the tests at 100% of its approved amount but it applied its approved amount for two tests, calcifediol and ferritin, to the Petitioner’s deductible for network services, leaving her responsible out-of-pocket for \$49.01.²

The Petitioner, believing the tests should be covered with no cost sharing, appealed BCBSM’s decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 4, 2015, affirming its decision. 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 laboratory services?

IV. ANALYSIS

Petitioner’s Argument

On the external review request form the Petitioner wrote:

I am seeking BCBSM to pay [REDACTED]
[REDACTED] \$49.01.

On Nov. 12, 2014, I phoned BCBSM inquiring if lab work order by my physician at my ACA [*Affordable Care Act*] yearly preventive physical exam would be covered as part of the ACA preventive physical exam. BCBSM’s representative told me “yes” to each lab code. I was not informed any one of the lab tests would be subject to a deductible and/or copay as I was specifically asking if they would be covered as part of the ACA preventive yearly exam, which has no copay or deductible.

Earlier the Petitioner had written an appeal letter to BCBSM dated January 21, 2015, in which she said:

On November 5, 2014, I received my yearly preventive physical screening exam as mandated by the Affordable Care Act. At that visit, my physician ordered preventive laboratory screenings which are also mandated by the Affordable Care Act.

² BCBSM’s approved amount for the collection of blood by venipuncture (CPT code 36415) was also applied to the network deductible.

On November 12, [2014], I called BCBS to verify each screening would be covered before proceeding to the lab. I spoke with BCBS representative [REDACTED] and gave her the specific test codes my physician ordered on the Laboratory Requisition as part of my yearly screening physical. She verified each screening test and assured me each test would be covered. At no time did she indicate Blue Cross would not pay for any one of these tests and that any one of the tests would be subject to a deductible.

On November 21, 2014, I proceeded to [REDACTED] laboratory to have the screenings completed.

I am now receiving a bill from [REDACTED] for \$49.01. I called and spoke with BCBS supervisor [REDACTED] on January 5, 2015, and he said based upon what I was told by your representative prior to having the laboratory tests completed this appeal would reverse BCBS decision.

Based upon the information your BCBS representative provided me with prior to my laboratory tests. I am asking BCBS to pay the \$49.01 billed by [REDACTED].

BCBSM's Argument

In its final adverse determination to the Petitioner, BCBSM wrote:

. . . As explained in Section 4, on page 4.20 of the *Certificate*, we pay for facility and professional benefits for preventive care services and immunizations mandated by the Patient Protection and Affordable Care Act (PPACA) at the time the service is provided. We will pay 100 percent of our approved amount; as your in-network outpatient deductible does not apply to PPACA mandated preventive care services.

In this instance, your primary care doctor ordered eight laboratory procedures during your annual physical. Five of the laboratory services are mandated by PPACA and BCBSM paid 100 percent of our approved amount for those laboratory services. However, not all laboratory services are mandated by PPACA as preventive services. Laboratory services that are not mandated as preventive services under PPACA are subject to your Plan's cost share requirements. For a list of PPACA mandated preventive benefits you may visit www.HealthCare.gov/center/regulations/prevention.html. In this case, procedure code 82306 (Calcifediol, 25-OH Vitamin D-3) and procedure code 82728 (Ferritin, T19181) are not PPACA mandated preventive care services; therefore, the services are subject to your Plan's outpatient in-network deductible requirement.

In addition, I reviewed your call to BCBSM prior to you receiving these laboratory services. You were correctly informed that the specific laboratory services were a benefit under your plan' however, there was no discussion regarding any cost share requirements related to these laboratory services. While I

regret you may have received incomplete information from a BCBSM agent/customer service representative, as a Grievance and Appeals Coordinator for BCBSM, it is my responsibility to ensure that the claim at issue processed according to Plan Design. As a result, I am not able to make an exception on your behalf. We must administer benefits in accordance with the terms of coverage.

In a position statement submitted on May 12, 2015, for this external review, BCBSM further explained its benefit determination:

[The Petitioner] received covered laboratory services on November 21, 2014. Procedure codes 36415, 82306 and 82728 were processed and paid at the BCBSM approved amount, subject to the member's annual deductible requirement. Because the procedure codes in question are not services mandated by PPACA as preventive, and because the member's in-network, inpatient family deductible requirement was not met at the time the services were rendered, the approved amount (\$49.01) applied appropriately to the deductible and remains the member's responsibility.

[The Petitioner's] request for external review indicates that she was advised by a BCBSM customer service representative on November 12, 2014 that the three procedure codes in question would be paid at 100 percent of the approved amount. A review of the telephone call was conducted. I confirmed that other than for the shingles vaccine, cost share for the laboratory services was not discussed. Additionally, BCBSM must administer benefits based on the terms and agreements of the member's contract.

* * *

In summary, BCBSM maintains the payment determination for the laboratory services rendered on November 21, 2014. In fact, no denial or rejection was made. BCBSM approved the services rendered and paid the claim at the approved amount less the member's cost share requirement. BCBSM respectfully requests that our determination be upheld in this matter.

Director's Review

The certificate (pp. 2.1, 2.4, and 2.5) explains that preventive care services are not subject the network deductible, copayments, or coinsurance. However, the certificate (p. 4.20) makes clear that not all preventive care services are exempt from cost sharing:

Preventive Care Services

We pay for facility and professional benefits for preventive care services and immunizations mandated by the Patient Protection and Affordable Care Act (PPACA) at the time they are provided, but only when obtained from a panel provider. Services obtained from a nonpanel provider are not a covered benefit.

We will pay 100 percent of our approved amount, not subject to any panel deductible, copayment or coinsurance requirements for the preventive care services and immunizations mandated by PPACA at the time they are provided. The Petitioner believes that she should not have any cost sharing for the laboratory tests her physician ordered as part of her yearly preventive physical exam.

The services that are covered with no cost sharing are those with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF)³ and those preventive care services for women supported by the federal Health Resources and Services Administration (HRSA).⁴

The calcifediol and ferritin tests and the venipuncture are not included in the mandated preventive care services from the USPSTF or HRSA, nor are they identified in the certificate as services that are not subject to cost sharing. Therefore, they are not exempt from the certificate's cost-sharing requirements and are subject to the annual outpatient in-network deductible requirement.

Therefore, the Director finds that BCBSM correctly applied its approved amount for those three services to the annual deductible for network (panel) services.

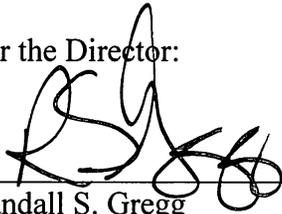
V. ORDER

The Director upholds BCBSM's final adverse determination of March 4, 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.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director

³ <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

⁴ <http://www.hrsa.gov/womensguidelines/>