

II. FACTUAL BACKGROUND

On March 4, March 5, and April 9, 2015, the Petitioners had laboratory tests and related services at a [REDACTED] hospital. BCBSM provided coverage but also assessed a deductible. On March 16, 2015, [REDACTED] had an electrocardiogram at [REDACTED], a medical practice in [REDACTED]. BCBSM denied payment for this procedure.

The Petitioners appealed, through BCBSM's internal grievance process, the assessment of deductibles and the amount BCBSM paid. At the conclusion of the grievance process, on June 18, 2015, BCBSM issued a final adverse determination affirming its decision. The Petitioners now seek the Director's review of BCBSM's final adverse determination.

III. ISSUE

Did BCBSM correctly process the Petitioners' March 4, March 5, March 16, and April 9, 2015 claims?

IV. ANALYSIS

Petitioner's Argument

In their request for an external review, the Petitioners wrote:

- 1) We are requesting to be billed the approved amounts we were quoted consistently and repeatedly by BCBSM reps. The approved amounts we were billed were up to five times more than what we quoted. We are snowbirds that live in [REDACTED] 6 months and [REDACTED] 6 months. We were told repeatedly by BCBSM reps, before buying the policy, after buying the policy and immediately before having these procedures performed that this policy would cover in both states. We said the tests were being performed in Florida when we obtained the price quotes from BCBSM reps. There has never been any mention of a "host plan" as referenced in their written response. The page 130 referenced in their response does not match the certificate on our BCBSM online account so we are not sure what certificate/policy they are referencing (see enclosed). The facilities we used were verified as "in-network" by BCBSM reps, shown on the BCBSM's website and by the facilities themselves. The BCBSM reps said as long as the tests were performed by "in-network" facilities that would be the approved amounts we would have to pay out-of-pocket.

[REDACTED]
3/5/15 [REDACTED] outstanding bill for \$350.12, quoted by BCBSM reps as a total of \$56.24

3/16/15 [REDACTED] outstanding bill for \$85.00, quoted by BCBSM reps as \$24.56.

[REDACTED]
3/5/15 [REDACTED] outstanding bill for \$350.78, quoted by BCBSM rep as a total of \$94.17

4/9/15 [REDACTED] outstanding bill for \$225.69, quoted by BCBSM reps as a total of \$160.85

- 2) We are also requesting that BCBSM pay for the venipuncture for routine laboratory blood tests that are supposed to be covered 100% as a preventive service under PPACA. Is there any way to do a 100% covered blood test without a venipuncture? No other blood tests were performed with it.

[REDACTED]
3/4/15 [REDACTED] outstanding bill \$9.18

[REDACTED]
3/4/15 [REDACTED] outstanding bill \$9.18.

BCBSM's Argument

In its final adverse determination, BCBSM's representative wrote:

Under your contract, payment for covered services is based on the approved amounts. Because your deductible had not been met at the time of the services, the approved amounts applied to them. As a result, you and your husband remain liable for the \$738.17 that applied to your deductible for laboratory and diagnostic radiology services.

* * *

The approved amounts that the [BCBSM] representatives provided to you for the requested services are for [REDACTED] providers for professional services (services provided by a physician). Because [REDACTED] Hospital is a [REDACTED] provider, we must apply the Host plan allowed amounts to the services. As it states on page 130 of your certificate "if you receive covered services from an out-of-area PPO network provider the provider will file your claim with the Host Plan and the Host Plan will pay the provider and not reduce its payment by the amount specified under this certificate for services provided by an out-of-network provider." I would also like to clarify that while you were advised the correct approved amounts for professional services, the providers in question billed your services as outpatient facility claims (for the use of the facility itself), as a result, facility services will have different approved amounts than professional services.

After confirming with the Host Plan in [REDACTED] I have determined that the approved amounts are correct, and you and your husband remain liable for the deductible requirement of \$700.90 for laboratory services and \$225.69 for

diagnostic services, which appropriately applied to your family deductible. Also, with reference to the dates of services of April 9, 2015, while you requested the allowed amounts for procedure code 77056, the provider's office billed the procedure code 77055.

Additionally, after review of the application of the deductible to procedure code 36415 (collection of venous blood by venipuncture), I have confirmed that the deductible correctly applied to the service. While preventive services are covered at 100 percent as mandated by the Patient Protection and Affordable Care Act (PPACA) and under your contract, the service is not payable as a preventive service, and therefore, the deductible applies as required by your contract.

Page 89 of your certificate, under **Section 3: What BCBSM Pays For**, states "to see a list of the preventive benefits and immunizations that are mandated by the Patient Protection and Affordable care Act.... You may also contact BCBSM customer services." Collection of [blood] by venipuncture is not a listed preventive service and therefore, the deductible applies.

Director's Review

The Petitioners are disputing the approved amounts calculated by BCBSM, arguing they were misled by BCBSM as the amounts quoted by BCBSM prior to service being rendered were lower than those actually applied and believe they should only be liable for the lower amounts quoted. In its final adverse determination, BCBSM explained why the approved amounts differed between the time of the initial estimate and the time the claims were submitted: BCBSM quoted the approved amount for professional services. However, the actual claims were submitted as facility services which have a different approved amount.

The claim for [REDACTED] March 16, 2015 electrocardiogram was determined by BCBSM to not be a covered benefit for the diagnosis code identified in the physician's claim. Therefore, this claim is not a question of BCBSM's calculation of the approved amount but rather is a claim denial.

The Petitioners also argue that the venipuncture should not have a deductible applied since it is related to a preventive service. As BCBSM correctly stated in its final adverse determination, only preventive services as designated by the United States Preventive Services Task Force are exempt from deductible requirements. The venipuncture procedure is not a deductible-exempt procedure.

The Director finds that BCBSM correctly processed the Petitioners' March and April 2015 claims.

V. ORDER

The Director upholds BCBSM's final adverse determination of June 18, 2015.

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