

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. 152294-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 5th day of April 2016
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) received certain prenatal services in 2015. Her health insurer, Blue Cross Blue Shield of Michigan (BCBSM), applied cost-sharing to those services, a decision the Petitioner disputes, and also denied coverage for an ultrasound.

On February 19, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's decisions under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On February 26, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives group health care benefits under a plan 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 March 4, 2016.

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 described in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs LG*¹ (the certificate). The certificate is amended by *Rider SBD-*

¹ BCBSM form no. 781E, effective 2015.

HSA-D 3000 / 6000-IN, 6000 / 12,000-ON LG Simply Blue HSA Deductible Requirement, which increased the in-network deductible to \$3,000 for a one-person contract and \$6,000 for a family contract.

In July, August, and October 2015, the Petitioner had radiology, laboratory, and pathology services performed at the Cleveland Clinic, a participating provider. BCBSM's approved amount for these services was \$2,980.31, and it applied that amount to the Petitioner's in-network deductible. BCBSM also denied coverage for an ultrasound on October 12, 2015, as medically unnecessary (a \$327.00 charge). This left the Petitioner responsible for \$3,307.31 out of pocket.

The Petitioner appealed BCBSM's decisions through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated January 7, 2016, affirming its decisions.

However, after the Petitioner filed her external review request with the Director, BCBSM reviewed the claims and said it would reprocess claims for two services performed on August 25, 2015, with no cost-sharing (CPT codes 85027 and 86901). BCBSM also said it would cover the ultrasound on October 12, 2015, as medically necessary, subject to the cost sharing requirements in the certificate.

After these adjustments, the Petitioner is responsible for out-of-pocket expense for services she believes should be covered with no cost sharing. The Petitioner now seeks a review of BCBSM's final adverse determination from the Director regarding the cost-sharing applied to the services she received.

III. ISSUE

Did BCBSM correctly apply a deductible to the services the Petitioner received in July, August, and October 2015?

IV. ANALYSIS

On the external review request form, the Petitioner wrote:

I have only been receiving routine care for prenatal visits. In my policy it states all prenatal care is covered and does not mention anything about meeting the deductible first. I don't want to be charged for something as the deductible for my routine prenatal care when it is to be covered.

The Petitioner referred to a BCBSM document that had a summary description of her health plan. That document indicates that "prenatal care visits" are covered "100% (no deductible or copay/coinsurance)." Based on that document, the Petitioner wrote a letter of appeal to BCBSM dated November 17, 2015, in which she said:

I have asked my doctor if all of the visits that I have attended was considered prenatal. She confirmed that they are all classified as prenatal and there is nothing special with my pregnancy. She said to contact Cleveland Clinic's billing department to make sure the

appointments were submitted to the insurance company with the correct code. After a few weeks of phone tag, they were able to determine that all of the claims were submitted as prenatal. That is what has led to this letter for an appeal of the charges. According to the EOB all of these visits should have been covered at 100% since they are all considered Prenatal Visits . . .

While the benefit summary the Petitioner refers to (“Benefits at a Glance”) indicates that prenatal care is covered with no cost-sharing, it is the certificate that controls. The benefit summary states:

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits at a Glance and any applicable plan document [*i.e., the certificate*], the plan document will control.

Nothing in the certificate’s description of the “Maternity Care” benefit (pp. 46-47), which includes prenatal care, indicates that it is not subject to the deductible. In its final adverse determination, BCBSM told the Petitioner:

You are covered under the *Simply Blue HSA Group Benefits Certificate*. On page 10 of your Certificate under **Section 2: What You Must Pay, Network Providers** it explains that you are required to pay a deductible each calendar year for covered services by in-network providers.

Thus, maternity care is generally subject to cost-sharing. However, the certificate, under the “Preventive Care Services” benefit (pp. 80-83), explains that certain services (which may be related to maternity and prenatal care) must be covered without cost-sharing as required by the federal Patient Protection and Affordable Care Act (PPACA). The Director reviewed the services the Petitioner received in July, August, and October 2015, and concludes that five of those services are preventive care that must be covered with no cost-sharing. They are:

<u>Date of Service</u>	<u>CPT Code</u>	<u>Description of Test</u>
August 20, 2015	87491	Chlamydia trachomatis
August 20, 2015	87591	Neisseria gonorrhoea
August 25, 2015	86780	Treponema pallidum (syphilis test)
August 25, 2015	87340	Hepatitis B surface antigen
August 25, 2015	87389	HIV-1 antigen

All five tests are on the list of services that have an A or B rating in the current recommendations of the United States Preventive Services Task Force and must be covered without any cost-sharing under PPACA.² All five tests also appear on BCBSM's list of preventive services procedure codes with no member cost-sharing. Three of the tests are specifically recommended for pregnant women (86780, 87340, and 87389). BCBSM has not refuted the Petitioner's contention that all these tests were routine screening tests conducted because of her pregnancy. Consequently, BCBSM must cover as preventive care services these five tests, as well as the two it had already agreed to cover (86901 and 85027).

The remaining tests the Petitioner received, including the ultrasounds, are subject to cost-sharing under the terms of the certificate.

V. ORDER

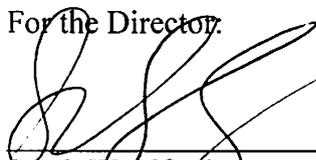
The Director reverses in part BCBSM's January 7, 2016, final adverse determination. BCBSM shall immediately reprocess the claims for these services without any cost-sharing: 87491, 87591, 86780, 87340, 87389, 86901, and 85027. Within seven days of reprocessing the claims, BCBSM shall furnish the Director with proof that it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Plans Division, toll-free 877-999-6442.

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 Director of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Sarah Wohlford
Special Deputy Director

² See 42 USC § 300gg-13 and 45 CFR § 147.130.