

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. 149127-001

Golden Rule Insurance Company,

Respondent.

Issued and entered
this 24th day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On August 3, 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.* After a preliminary review of the material received, the Director accepted the request on August 10, 2015.

The Petitioner receives health benefits through a plan that is underwritten by Golden Rule Insurance Company (Golden Rule). The Director notified Golden Rule of the external review request and asked for the information it used to make its final adverse determination. Golden Rule responded on August 4, 2015.

This case presents an issue of contractual interpretation. 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 a certificate of insurance issued by Golden Rule. The coverage was obtained by the Petitioner through the Federation of American Consumers and Travelers, and while it is called an association group plan, it is considered to be individual coverage in Michigan.

On June 12, 2014, the Petitioner had an annual physical examination that included certain laboratory tests. Golden Rule covered a lipid panel (CPT code 80061) and the thyroid stimulating hormone test (CPT code 84443) without any cost sharing.

Golden Rule also covered three other tests, basic metabolic panel (CPT code 80048), complete blood count (CPT code 85027), and vitamin D (CPT code 82306), but applied \$114.40 to the Petitioner's network deductible before making its payment of \$92.80 to the laboratory provider.

The Petitioner believed that those three tests should be covered as preventive care services without any cost sharing. She appealed Golden Rule's claims processing decision through its internal grievance process. At the conclusion of that process, Golden Rule issued a final adverse determination dated June 9, 2015, affirming its decision.

The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did Golden Rule correctly process the claims for the Petitioner's laboratory tests on June 12, 2014?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that all three tests are preventive care services and must be covered without any cost sharing according to the federal Patient Protection and Affordable Care Act (PPACA or "Obamacare"). In a letter filed with her external review request the Petitioner said:

. . . The Basic Metabolic Panel is to check for kidney function, blood acid/base balance and blood sugar levels. According to Obamacare, adults with risk for Diabetes should be screened and it should be covered. My mom is diabetic and they are closely monitoring her kidneys due to past issues and lab levels. My MD ordered this to ensure that everything was functioning properly.

In regards to the Vitamin D, it states that Depression Screening is part of preventative care and should be covered 100% by insurance. I live in Michigan where 6 months of the year it is winter, gray, dark, cold weather and checking vit D levels is considered preventive care. . . .

Lastly in regards to the CBC [*complete blood count*] lab, Obamacare considers a CBC a part of a routine anemia check for woman as part of their yearly exams. I am a menstruating female who has regular, heavy periods. It is important to know

that my CBC labs are within normal range. This test also checks for labs that can be affected by the condition of the heart. My mom has CAD (Coronary Artery Disease) and had to have a heart stent placed. . . . In regard to all these labs is it not better for insurance to pay a small amount to make sure everything is fine with a patient with preventive care versus paying thousands of dollars if something was wrong and I was not aware of it because no labs were done? . . .

Respondent's Argument

In its final adverse determination, Golden Rule explained its claim processing decision to the Petitioner:

. . . It is the decision of the reviewing panel to uphold the original benefits applied to [REDACTED] claim from June 12, 2014. Additional benefits are not available. The rationale behind the decision is provided below.

Your health insurance plan includes a Preventive Care Expense Benefits provisions. We would like to explain the Preventive Care benefits that are included in the federal Patient Protection and Affordable Care Act (PPACA).

These preventive services are covered without a deductible, copay or coinsurance, when a preferred or network provider is used. Covered preventive are those services described in one of the following: A and B recommendations of the United States Preventive Task Force (USPSTF); Advisory Committee on Immunization Practices (ACIP) recommendations; and Health Resources and Service Administrative guidelines for women and children. Please note however, these may change as the recommendations and guidelines change.

Golden Rule explained why it covered the lipid panel (CPT code 80061) and the thyroid stimulating hormone test (CPT code 84443) without cost sharing:

The lipid panel (80061) is eligible for under health care reform regulations. This expense was reimbursed at 100% of the repriced amount. In addition, the TSH [*thyroid stimulating hormone*] was reimbursed at 100%; however, this test is eligible under health care reform regulation for newborn age 0-90 days old. It the panel's decision to allow this expense to remain as originally processed.

Regarding the other three tests, Golden Rule said:

The remaining laboratory tests: Basic metabolic panel (80084), Vitamin D (82306), and Blood count complete (85027) are not eligible under health care reform regulation as these tests are not in accordance with the recommendations of the USPSTF. Therefore, these expenses were processed under your plan's Medical Benefits provision and applied to your network provider deductible.

Director's Review

The PPACA requires health plans and health insurers offering group or individual health insurance coverage to provide benefits for certain preventive care services without imposing cost-sharing requirements. See 42 USC § 300gg-13 and regulations at 45 CFR §147.130. The certificate, under "Preventive Care Expense Benefits" (p. 22), explains which services must be covered without cost sharing:

Covered expenses will include charges incurred by a covered person for the following preventive health services if appropriate for the covered person and in accordance with the following recommendations and guidelines in effect as of March 23, 2010.

- (A) Evidence based items of services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force [*USPSTF*].
- (B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the centers for Disease Control and Prevention with respect to an individual.
- (C) Evidence-informed preventive care and screening for infants, children and adolescents in accordance with comprehensive guidelines supported by the Health Resources and Services Administration, and
- (D) Additional preventive care and screenings not described in (A) above, in accordance with comprehensive guidelines, supported by the health Resources and Services Administration for women.

Benefits for preventive health services are exempt from deductible amounts, coinsurance and copayment amounts when services are provided by a network provider.

The Petitioner says that the basic metabolic panel (CPT code 80048) was necessary to screen for diabetes. While the USPSTF has a B-rated recommendation for screening for type 2 diabetes in adults, a basic metabolic panel is not the test used; rather the tests used are a fasting plasma glucose, a 2-hour postload plasma glucose, or a hemoglobin A1C.

The Petitioner further says that a vitamin D test (CPT code 82306) is necessary preventive care for depression. Depression screening in adults is also a B-rated recommendation of the USPSTF but the screening is conducted initially through a series of simple questions, not a vitamin D test.

Finally, the Petitioner says the complete blood count (CPT code 85027) is necessary as "part of a routine anemia check for woman as part of their yearly exams" and to determine heart

conditions. However, the USPSTF only “recommends routine screening for iron deficiency anemia in asymptomatic pregnant women” (B-rated). There is nothing in the record to show that the Petitioner was pregnant at the time she had the test. Also, there is no A- or B-rated recommendation from the USPSTF related to screening for coronary heart disease using non-traditional risk factors in asymptomatic adults with no history of CHD to prevent CHD events.

Based on the foregoing, the Director concludes that Golden Rule correctly determined that the basic metabolic panel, complete blood count, and the vitamin D test were not preventive care services that are exempt from cost sharing.

V. ORDER

The Director upholds Golden Rule’s June 9, 2015, 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 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