

This case involves medical issues so the Director assigned it to an independent review organization which provided its analysis and recommendation to the Director on March 14, 2016.

II. FACTUAL BACKGROUND

The Petitioner is [REDACTED] years old and has type 1 diabetes. He uses a continuous glucose monitor to control his glucose levels. He sees an endocrinologist four times a year and has his A1c level checked. The doctor also downloads and evaluates the information stored in the Petitioner's glucose monitor.

On December 7, 2015, the Petitioner had an appointment with his endocrinologist. A claim was submitted to BCBSM – \$141.00 for the office visit (procedure code 99214) and \$76.00 for interpreting the glucose monitor data (procedure code 95251).¹ BCBSM paid its approved amount (\$113.35) for the office visit but denied coverage for interpreting the glucose monitor data.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination dated February 2, 2016, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Is BCBSM required to provide coverage for the physician interpreting the glucose monitor data?

IV. ANALYSIS

BCBSM's Argument

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

Your group's health care plan does not pay for more than two blood glucose monitoring readings by a physician (procedure code 95251: ambulatory continuous monitoring of intestinal tissue fluid via subcutaneous sensor for up to 72 hours; physician interpretation and report), for each member, for each calendar year. You remain liable...for the \$76.00 for the non-covered service.

You are covered under the *Simply Blue HSA Group Benefit Certificate with Prescription Drug LG*. As indicated on page 66, you have coverage for an

1. Procedure codes are found in the American Medical Association's manual, *Current Procedural Terminology*. The codes, usually five digit numbers, are commonly referred to as "CPT codes" or "procedure codes" and are used by providers of medical services to describe the services when claims are submitted to insurers.

outpatient diabetes management program. This program includes the use of blood glucose monitors. In addition, page 32 of your certificate states that you have coverage for diagnostic testing services, which includes the reading and interpretation of your blood glucose monitoring system. However, this coverage has its limitations. This is supported by the *Blue Cross Blue Shield of Michigan Benefit Package Report* for your group, which states that procedure code 95251 (ambulatory continuous monitoring of intestinal tissue fluid via subcutaneous sensor for up to 72 hours; physician interpretation and report) is only payable for up to two visits for each member, each calendar year.

I confirmed that our records show you had previously received two services for blood glucose monitoring readings in 2015 (April 10 and August 17, 2015). I understand your concern regarding the charges for this service. However, BCBSM must administer benefits according to the terms of your group's health care plan. Your group's health care plan does not allow for payment of more than two blood glucose readings per member, per calendar year. Because you had received two previous blood glucose readings in 2015, payment for the December 7, 2015 date of service cannot be approved.

Petitioner's Argument

The Petitioner wrote in his request for an external review:

I am asking for an external review in regards to a denied claim from [BCBSM] in regards to an A1c blood reading test that they have declined to cover (new/change for 2015). According to their new policies I am only covered for these two times per year and they have denied my appeal to increase this to four times per year based on my doctor's note.

I am a Type 1 diabetic and I see an endocrinologist four times per year. Each appointment I have a blood draw to determine my A1c levels to determine if my insulin regimen is correct or needs to be tweaked. I have been a Type 1 for 10 years and insurance has always covered these tests, until recently.

I have included my doctor's note, which includes the necessity of the test to avoid future complications, along with an explanation of the procedure and my current treatments (insulin pump).

I am challenging this ruling based on medical necessity....

Director's Review

The *Simply Blue* certificate of coverage (page 66) contains this provision:

We pay for:

Selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O.

BCBSM does not challenge the Petitioner's assertion that a blood glucose monitor is medically necessary. BCBSM asserts that it is only obligated to provide coverage twice a year to have the monitor's stored data read and interpreted.

The Director requested that an independent review organization (IRO) analyze BCBSM's claim processing for the December 7, 2015 physician appointment. The Director is required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6), to employ an IRO to analyze appeals that present medical questions. The IRO reviewer is a physician in active practice who is certified by the American Board of Internal Medicine with a subspecialty in endocrinology, diabetes and metabolism. The reviewer is an instructor at a university medical school and is published in peer reviewed medical literature. The reviewer was asked to address the following question:

Was Procedure Code 952251 (ambulatory continuous glucose monitoring of intestinal tissue fluid via subcutaneous sensor up to 72 hours; physician interpretation and report) provided [the Petitioner] on December 7, 2015, medically necessary for treatment of his condition?

The IRO report included the following analysis and recommendation.

According to the documentation submitted for review, the seventy two (72) hour interpretation is not what was being done in this case. In this case, it appears as if the CGM data for several weeks is downloaded at each office visit and reviewed. This is what the attending provider is asking for in a letter dated January 13, 2016 and what is actually being done; not seventy two (72) hour review of CGM data which is usually done one to two times per year as the plan suggests.

The enrollee has hypoglycemia and hypo unawareness. Using a CGM to help avoid severe lows, to help avoid severe highs, and to help the enrollee improve A1C and overall control is what the CGM is being used for in this case. Using CGM is such an enrollee, is standard of care and the 530g with enlite is the pump system being used here. It is being worn all the time – not just temporarily as some CGM's are worn. Hence, the interpretation of the CGM data at each visit is justified but an incorrect procedure code is being utilized as it is not for just seventy two hours of monitoring.

The IRO reviewer recommended that the Director affirm BCBSM's claim denial because the provider submitted the claim using an incorrect procedure code. The Director accepts the IRO's conclusion that an incorrect procedure code was submitted to BCBSM.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned

independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on experience, expertise, and professional judgment. In addition, the IRO's recommendation is not contrary to any provision of the Petitioner's certificate of coverage. MCL 550.1911(15).

As an insurer, BCBSM is obligated to process claims according to the procedure code submitted by the provider (in this case, the Petitioner's endocrinologist). Had a procedure code been used which reflected the actual service provided, BCBSM might have been obligated to pay the claim. However, the Director also notes that in some cases, an insurer will conclude that an office visit claim covers all the physician services provided during the visit and, for that reason, will approve coverage for only one procedure code. It cannot be determined whether such a policy would apply in this case.

Based on the records submitted by the parties for this review, the Director cannot conclude that BCBSM is obligated to provide coverage for interpreting glucose monitor data. If the provider elects to submit an amended claim, BCBSM may choose to provide coverage. In the event the claim is again denied, the Petitioner would be able to pursue a second appeal. However, at present, the Director finds no basis for reversing BCBSM's denial of coverage for procedure code 95251.

V. ORDER

The Director upholds BCBSM's final adverse determination of February 2, 2016.

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 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