STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Joanna Roa, Appellant, vs. South Carolina Public Employee Benefit Authority, Employee Insurance Program, Respondent.	)))))))))))	Docket No. 18-ALJ-30-0276-AP **ORDER**

CERTIFICATE OF SERVICE
[illegible]
This 6 day of May, 2019
By: Judicial Law Clerk

STATEMENT OF THE CASE

This matter is before the Administrative Law Court (ALC or Court) pursuant to a Notice of Appeal filed by Joanna Roa (Appellant). Appellant seeks review of a final decision issued by the South Carolina Public Employee Benefit Authority, Employee Insurance Program's Health Appeals Committee (PEBA or Committee) denying Appellant's claim for benefits for reverse T3 lab testing. Upon consideration of the arguments raised in the parties' briefs and a review of the record, pertinent policy provisions, and applicable law, the court affirms the agency determination.

BACKGROUND

Appellant has been enrolled as a participant in the Standard Plan, part of the South Carolina Group Health Benefits Plan (Plan) since November 1, 2015. Blue Cross Blue Shield of South Carolina (BCBSSC) is the third party claims administrator for the Plan. In 2015 and 2016, Appellant underwent reverse T3 lab testing on five distinct dates of service and each claim was eligible for benefits and paid by the Plan. Also, in 2016 BCBSSC Corporate Administrative Medical (CAM) created a policy regarding reverse T3 lab testing (CAM 135). CAM 135 distinguished reverse T3 lab testing from other thyroid lab testing and stated T3 was investigational in nature. BCBSSC communicated the CAM change on its website and used provider educators to update providers on the change. BCBSSC began utilizing CAM 135 for reverse T3 lab testing in January 2017. On July 11, 2017 and August 22, 2017, Appellant underwent reverse T3 lab testing, and the provider filed claims with BCBSSC. BCBBSSC processed the claims using CAM 135 and issued an Explanation of Benefits (EOB) as to each claim denying coverage. In the EOBs, BCBBSSC explained Appellant was responsible for all charges because the Plan does not cover

FILED
MAY 06 2019
SC ADMIN. LAW COURT

investigational services. Appellant contacted BCBSSC to discuss the denial of her claims at which time Appellant was advised of her right to appeal the denials.

Dr. Jose R. Fernandez, the provider who prescribed Appellant's reverse T3 lab testing, sent a letter dated September 14, 2017 to BCBSSC explaining that Appellant was diagnosed with hypothyroidism. He further explained that Appellant had four fetal deaths that were caused by her hypothyroidism, and he believes reverse T3 testing is medically necessary for Appellant to avoid further pregnancy complications. On September 26, 2017, Appellant appealed the denial of her claims. In her appeal letter, Appellant stated her reverse T3 lab testing claims were covered on at least 5 prior occasions; and she and her physician, Dr. Fernandez, both believe the tests are medically necessary, are not investigational and qualify for coverage under the Plan. On September 28, 2017, BCBSSC notified Appellant that her appeal and any other information that was provided was being reviewed.

Lena Bretous, M.D., BCBSSC's medical director and a board-certified physician, reviewed Appellant's file. Dr. Bretous concluded that in accordance with CAM 135, Appellant's claims were properly denied because reverse T3 lab testing was investigational and not eligible for coverage. Specifically, Dr. Bretous determined there was insufficient evidence-based guidelines to support long-term improved clinical outcomes with reverse T3 testing.

On November 10, 2017, BCBSSC sent Appellant a letter denying her appeal, and advised Appellant of her right to appeal further to PEBA. Appellant submitted her appeal to PEBA's Appeals Department on December 15, 2017. The appeal letter to PEBA was substantially the same as Appellant's prior appeal letter to BCBSSC. On January 5, 2018, PEBA received additional information from Appellant that included Dr. Fernandez's notes and her lab results. In light of this new information, PEBA requested that BCBSSC review Appellant's case again to determine whether this additional information would impact its decision denying her claim.

Ervin Jones, M.D., Board Certified in Obstetrics and Gynecology, conducted an independent review of Appellant's file. Dr. Jones issued a report of his findings on February 7, 2018. He reported that Appellant's records contained no laboratory tests results documenting hypothyroidism or hyperthyroidism or other substantive documentation of thyroid disease. Dr. Jones also reported there was no indication in the records that Appellant's conditions of fatigue and infertility were caused by thyroid disease, and that there was "no peer-reviewed evidence that measurements of reverse T3 change health outcome." In the report Dr. Jones concluded that in

Appellant's case "measurements of reverse T3 in isolation must be considered experimental and investigational." He further concluded that this testing was not medically necessary and was not the standard of care in Appellant's clinical situation.

The Committee subsequently conducted a review of all the evidence in Appellant's file and issued a final decision on July 2, 2018 upholding BCBSSC's denial of Appellant's claim for coverage of her T3 lab testing. The Committee's basis for denial was that the services were investigational and not medically necessary. Appellant filed this appeal to the ALC on July 30, 2018.

ISSUE ON APPEAL

Whether substantial evidence exists in the record to support the Committee's decision denying Appellant's claim for coverage of reverse T3 lab testing.

STANDARD OF REVIEW

The Board of Directors of PEBA is the final arbiter of disputes under the Plan. S.C. Code Ann. § 1-11-710(C) (Supp. 2016). Section 1-11-710(C) provides:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by the procedures established by the board, which shall include the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380.

Under PEBA's claims procedures, which are set forth in Article 12 of the state's Plan of Benefits, a claim for benefits is reviewed by the Third Party Claims Processor,[1] with final agency appeal to the Plan Administrator in the form of PEBA's Health Appeals Committee.

Pursuant to the Administrative Procedures Act, the Court sits in its appellate capacity in this matter. S.C. Code Ann. §§ 1-11-710(C) & 1-23-660(D) (Supp. 2016). The court's review is limited to the record. S.C. Code Ann. § 1-23-380(4) (Supp. 2016). In accordance with Section 1-23-600(E), when acting in an appellate capacity, the court must apply the criteria of Section 1-23-380(5), which states:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

[1] In this case, the Third Party Claims Processor is Medi-Call.

(a) in violation of constitutional or statutory provisions;
(b) in excess of the statutory authority of the agency;
(c) made upon unlawful procedure;
(d) affected by other error of law;
(e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
(f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Id.

This section requires the ALC to apply the "substantial evidence" rule. *See e.g., Waters v. S.C. Land Res. Conservation Comm'n*, 321 S.C. 219, 467 S.E.2d 913 (1996); *Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm'n*, 282 S.C. 430, 319 S.E.2d 695 (1984). Substantial evidence is "'not a mere scintilla of evidence nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached . . . .'" *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 135, 276 S.E.2d 304, 306 (1981) (citation omitted). A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. *Bilton v. Best W. Royal Motor Lodge*, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). The possibility of drawing two inconsistent conclusions from the evidence does not mean the agency's conclusion is unsupported by substantial evidence. *Id. See also, Waters*, 321 S.C. at 227, 467 S.E.2d at 917 (*citing Palmetto Alliance, Inc. v. South Carolina Pub. Serv. Comm'n*, 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct and will be set aside only if unsupported by substantial evidence. *Rodney v. Michelin Tire Co.*, 320 S.C. 515, 518, 466 S.E.2d 357, 358 (1996) (*citing Kearse v. State Health and Human Serv. Fin. Comm'n*, 318 S.C. 198, 456 S.E.2d 892 (1995)). Thus, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. *Waters*, 321 S.C. at 226, 467 S.E.2d at 917 (*citing Hamm v. AT & T*, 302 S.C. 210, 394 S.E.2d 842 (1994)).

Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. *Grant v. SC Coastal Council*, 319 S.C. 348, 353, 461 S.E.2d 388, 391 (*citing Gibson v. Florence Country Club*, 282 S.C. 384, 386,

318 S.E.2d 365, 367 (1984)). However, "[d]etermining the proper interpretation of a statute is a question of law, and [an appellate court] reviews questions of law de novo." *Palmetto Co. v. McMahon*, 395 S.C. 1, 3, 716 S.E.2d 329, 330 (Ct. App. 2011) (citation omitted).

DISCUSSION

The State Health Plan is an insurance contract, and the cardinal rule of contract interpretation is to ascertain and give effect to the intention of the parties. *Chan v. Thompson*, 302 S.C. 285, 289, 395 S.E.2d 731, 734 (Ct. App. 1990). In determining the intentions of the parties, the court first looks to the language of the contract. *C.A.N. Enters., Inc. v. S.C. Health & Human Servs. Fin. Comm'n*, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988). If the language is clear and unambiguous, the language of the contract alone determines the contract's force and effect. *Conner v. Alvarez*, 285 S.C. 97, 101, 328 S.E.2d 334, 336 (1985).

"Contracts of insurance, like other contracts, should be interpreted according to general rules of construction and the language employed is to be understood in its plain, ordinary and popular sense." *Universal Underwriters Ins. Co. v. Metro. Prop. & Life Ins. Co.*, 298 S.C. 404, 406, 380 S.E.2d 858, 860 (Ct. App. 1989). "The rights of the parties must be measured by the contract which the parties themselves made, regardless of its wisdom, reasonableness, or failure of the parties to guard their rights carefully." *Chan*, 302 S.C. at 289, 395 S.E.2d at 734. "Parties to a contract of insurance have the right to make their own contract." *Sphere Drake Ins. Co. v. Litchfield*, 313 S.C. 471, 473, 438 S.E.2d 275, 277 (Ct. App. 1993). "It is not the function of the court to rewrite or torture the meaning of the policy to extend coverage." *Id.* Simply put, "[c]ourts must enforce, not write, contracts of insurance." *Beaufort County Sch. Dist. v. United Nat. Ins. Co.*, 392 S.C. 506, 516, 709 S.E.2d 85, 90 (Ct. App. 2011).

Relevant Plan and Policy Language.

Article 2, Section 2.49 of the Plan defines Medical Necessity, Medically Necessary, or Necessary Service and Supply as a procedure, service or supply that meets all of the following criteria:

A. Is required to identify or treat an existing condition, illness or injury;
B. Is prescribed or ordered by a Physician; and
C. Is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
D. Is required for reasons other than the convenience of the patient.

> The fact that a procedure, service or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not automatically mean that such procedure, service or supply is Medically Necessary or meets the definition of Medical Necessity in [the] Plan.

In Appellant's case, the Committee determined that under criterion C the reverse T3 lab testing was not medically necessary. Additionally, Section A of the Plan's Article 9 [Exclusions and Limitations] states that "[n]o benefits will be provided under any Article of this Plan for [a]ny service, supply, or charge for service which is not Medically Necessary."

Section G of the Plan's Article 9 further states that:

> Any surgical or medical procedures determined by the medical staff of the Third Party Claims Processor, with appropriate consultation, to be experimental, investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs that, at the time provided or sought to be provided:
> 1. Are not recognized as conforming to acceptable medical practice in the relevant medical specialty or field of medicine; or
> 2. Have not received final approval to market from appropriate government bodies; or
> 3. Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
> 4. Are not demonstrated to be as beneficial as established alternatives; or
> 5. Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
> 6. Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Any one of the above six criteria is sufficient to make a finding that a service is investigational and thus, ineligible for pre-authorization under the Plan. Following review of the evidence submitted, including the opinion of a medical reviewer, the Committee determined the reverse T3 lab testing met criterion 3 and 5.

The Committee also considered relevant portions of BCBSSC's Corporate Administrative Medical (CAM) policy regarding reverse T3 lab testing, published prior to BCBSSC's utilization of the change. CAM 135 specifically addresses thyroid disease testing and testing of reverse T3 levels. CAM 135(5) states "[t]esting of Reverse T3 INVESTIGATIONAL."

On appeal, Appellant acknowledges that reverse T3 lab testing is not currently covered under the Plan and is not contesting the Committee's determination that this testing is not

medically necessary. However, Appellant argues the Court should reverse PEBA's decision because she had no knowledge or reasonable way of knowing about the policy change that caused reverse T3 lab testing to no longer qualify for coverage under the Plan. She contends she was unaware of publication of the CAM change on BCBSSC website and complains that the website is not easily navigable by patients, and the notice given was insufficient to put ordinary patients on notice of changes in the Plan. Appellant argues CAM 135, and the termination of coverage of her reverse T3 lab testing, is unfair because it is contrary to her expectations, which she contends were reasonable. She makes it clear in her brief that she does not expect future reverse T3 lab testing to be covered but is requesting that this Court order that the previously denied claims associated with this testing be covered under the Plan.

Appellant's arguments are equitable in nature and she fails to clearly specify or support with case law or other authority any reason why the Court can and should reverse the Committee's decision. *See First Sav. Bank v. McLean*, 314 S.C. 361, 363, 444 S.E.2d 513, 514 (1994) ("Mere allegations of error are not sufficient to demonstrate an abuse of discretion."). And, while the Court may be sympathetic to Appellant's unfortunate situation, the Plan's language, when reviewed along with the medical summaries, offer substantial evidence to support PEBA's decision to deny Appellant's claim for coverage of her reverse T3 lab testing.

CONCLUSION

Following a thorough review of this matter, this Court must affirm the Committee's decision to deny Appellant's claim for Plan coverage of reverse T3 lab testing. Substantial evidence exists in the record to support the Committee's decision, and the decision is not arbitrary or capricious, or characterized by an abuse of discretion.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED** that the decision of the South Carolina Public Employee Benefit Authority, Employee Insurance Program's Health Appeal Committee is **AFFIRMED**.

AND IT IS SO ORDERED.

SHIRLEY C. ROBINSON
Administrative Law Judge

May 6, 2019
Columbia, South Carolina