

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. 151408-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 12th day of January 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 21, 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.* On December 30, 2015, after a preliminary review of the information submitted, the request was accepted.

The Petitioner receives health care coverage under a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Simply Blue Group Benefits Certificate LG*. The benefit plan's deductibles are defined in *Rider SBD-IN \$500/\$1000 LG Simply Blue Deductible Requirement for In-Network Services*.

The Director notified BCBSM of the external review request and asked for the information it used to make its adverse determination. The Director received BCBSM's response on January 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

On August 5, 2015, the Petitioner received several prenatal care services: an office visit with her doctor, an ultrasound, and several blood tests. BCBSM approved the claims for these services but assessed cost sharing in the form of deductibles, coinsurance, and a copayment.

Details of the claims are found in a BCBSM Explanation of Benefits form issued on August 14, 2015.

BCBSM later determined that it had erred in charging the Petitioner a \$20.00 copayment for her prenatal office visit and subsequently reprocessed the office visit claim and agreed to pay the Petitioner's doctor an additional \$20.00. BCBSM issued a corrected Explanation of Benefits form on October 30, 2015 showing that the \$20.00 copayment had been eliminated. BCBSM made no changes to its processing of the other claims.

In her request for external review, the Petitioner is contesting BCBSM's claim processing for her August 5 prenatal visit and other visits that occurred between August 5 and September 10, 2015. The Petitioner had three prenatal care office visits after August 5 and before the birth of her child on September 11, 2015.

In conducting external reviews under the Patient's Right to Independent Review Act, the Director is limited to considering appeals in which an individual has completed the insurer's internal grievance process. See section 11(2) of the Patient's Right to Independent Review Act, MCL 550.1911(2). The Petitioner has only completed the BCBSM internal grievance process for the August 5 claims. For that reason, the Director will conduct an external review of the August 5 claims only.

III. ISSUE

Did BCBSM correctly process the claims for the prenatal care the Petitioner received on August 5, 2015?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination, BCBSM wrote:

[T]he services you received on August 5, 2015 at [REDACTED] MFM are related to prenatal care. Thus, the claim for the prenatal office visit was reprocessed and the copayment was waived. As a result, an additional payment in the amount of \$20.00 will be sent to [REDACTED] MFM soon. The total charge submitted for the prenatal office visit was \$235.77. Our previous payment (\$82.72) together with our additional payment (\$20.00) represents 100 percent of our approved amount.

Regarding the radiology services you received on August 5, 2015 at [REDACTED] MFM, the total charge submitted was \$1,281.03 and our total approved amount is \$447.57. Because your annual in-network deductible requirement was not met when the claim was processed, our approved amount was applied towards your in-network deductible requirement...

* * *

Regarding the laboratory services you received on August 5, 2015 at [REDACTED], the total charge submitted was \$383.97 and our total approved amount is \$88.42. A payment totaling \$28.79 was sent to your provider. We applied \$52.43 towards your in-network deductible requirement. We also applied \$7.20 towards your in-network provider coinsurance requirement.

Because the providers participate with the host plan, BCBS of [REDACTED] they will accept our approved amounts as payment in full.

Lastly, in your appeal letter, you stated that you believe that all prenatal care is covered at 100 percent and not subject to the deductible, copayment or, coinsurance requirements. To clarify, according to Page 60 of the [*Simply Blue Group Benefits Certificate*]:

Office, Outpatient and Home Medical Care Visits

The following are examples of services that will not require any co-payments when provided in an in-network physician's office:

- Prenatal care
- Presurgical consultation

As explained above, prenatal care, as outlined in your *Certificate* under Office, Outpatient and Home Medical Care Visits, explains that prenatal care will not require a copayment when provided in an in-network physician's office. Thus, copayment is the only cost share requirement that is waived for prenatal care. As a result, the copayment requirement was waived for your prenatal office visit you received on August 5, 2015.

Petitioner's Argument

In her request for external review the Petitioner wrote:

[Blue Cross Blue Shield of Michigan] charged copays, coinsurance, and deductibles for prenatal care office visits contrary to their benefits summary. They asserted the charges are applicable to all office visits, in spite of a separate summary category for prenatal visits that states "100% (no deductible or co-pay/coinsurance)"...I contested and BCBS determined that (1) the visits were prenatal care visits; (2) the copay was improperly charged (based on the manual listing prenatal copays as an example of when an office visit copay is not charged); and (3) that deductibles apply to prenatal visits (because they were not given as an example of when a charge is not made for an office visit); and (4) Coinsurance applies to all office visits (because the manual says "most"). I seek reimbursement for deductibles, copays and coinsurance charged on the 8-5 and subsequent prenatal visits. Note: August 5 was the first visit covered by [Blue Cross Blue Shield of Michigan]. Prior, I was covered by [Blue Cross Blue Shield of [REDACTED]] and, under the same summary language, no charges were made to patient.

Director's Review

Concerning the copayment charge for the August 5 office visit, the Director notes that the charge has already been eliminated by BCBSM. The elimination of the copayment is consistent with the terms of the Petitioner's benefit plan. According to the Explanation of Benefits form of October 30, 2015, BCBSM did not impose any cost sharing requirements for the Petitioner's prenatal office visits (i.e., no deductible, copayment, or coinsurance).

Concerning BCBSM's processing of the claims for the August 5 laboratory tests and ultrasound, the Director notes that these medical services are governed by separate provisions in the *Simply Blue Group Benefit Certificate*. Coverage for laboratory services is described on page 34 of the *Certificate*. Coverage for ultrasounds is described on page 86 of the *Certificate* under "Radiology Services." There is no provision in the *Certificate* that would prohibit BCBSM from charging deductibles, copayments, or coinsurance for those services.

Maternity care coverage is described on pages 50-52 of the *Certificate*. Prenatal care is covered under this section of the *Certificate* but there is no provision that cost sharing is waived for maternity care. As noted above, the only prenatal care section of the *Certificate* which provides for waiver of cost sharing is the provision relating to office visits. That section states that office visits for prenatal care do not require a copayment.

V. ORDER

The Director upholds BCBSM's final adverse determination of October 12, 2015.

This is a final decision of an administrative agency. 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 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