

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. 151277-001-SF

City of Plymouth, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this **5th** day of January 2016
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner), a minor,¹ was denied coverage for behavioral health services by his health plan.

On December 11, 2015, ██████████, the Petitioner's father, filed a request with the Director of Insurance and Financial Services for an external review of that denial under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on December 18, 2015.

The Petitioner receives health care benefits as an eligible dependent through a plan sponsored by the City of ██████████, a self-funded governmental health plan subject to Act 495 (the plan). Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director immediately notified BCBSM of the external review request and asked for the information it used to make the plan's final adverse determination. The Director received BCBSM's response on December 22, 2015.

██████████.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The issue in this external review can be decided by a contractual review. 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

According to BCBSM, at the time the Petitioner was admitted for treatment his health care benefits were defined in BCBSM's *Community Blue Group Benefits Certificate ASC* (the certificate).²

From January 6 to May 31, 2015, the Petitioner received residential behavioral health care at [REDACTED] in [REDACTED]. The charge for this care was \$51,100.00. [REDACTED] is not in the plan's PPO network nor does it participate with BCBSM.

BCBSM denied coverage because the provider is a nonparticipating facility. The Petitioner appealed the denial through the plan's internal grievance process. At the conclusion of the process BCBSM affirmed the denial and issued a final adverse determination dated October 15, 2015. The Petitioner now seeks a review of that final adverse determination by the Director.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's mental health services at [REDACTED] [REDACTED]?

IV. ANALYSIS

Petitioner's Argument

In his external review request the Petitioner's father said:

BCBS of Michigan has denied, in full, a claim for our son for in patient mental health care. We believe we do in fact have coverage for a portion of the cost.

Prior to sending him we reviewed our coverage. Our Benefits-at –a Glance document, issued by BCBS, noted that coverage for inpatient mental health care at an out-of-network provider is covered at 80% after the out-of-network deductible is reached. There is a footnote that states "If you receive care from a

² BCBSM form no. 457F, effective 01/15.

nonparticipating provider, even when referred, you may be billed for the difference between the approved amount and the provider's charge." As a nonparticipating provider, I believe they would be considered out-of-network.

The provider also called BCBS to verify coverage. They were told "preauthorization was not require for out-of-network providers" for the mental health treatment they would provide.

He was admitted into a residential treatment center from 01/05/2015 - 09/05/2015.³ He received between 15-20 therapy (individual, group & family) sessions each week. He also saw a psychiatrist regularly for medication prescriptions, monitoring, changes and adjustments.

When the provider submitted claims to BCBS, they were denied in full. The reason noted was "The Provider's Blue Cross Blue Shield plan has no participating contract with the provider. If this provider sends you a bill, you should expect to pay the difference between the charge and out payment."

It has been our understanding all along that once the deductible was reached, we would pay 20% plus any difference in charges. Yet the claim was denied in full.

We appealed the denial and were told that "Your health care coverage does not pay for this service when performed by a non-participating provider." This reason does not seem valid. The footnote on the BCBS Benefits-at-a-Glance indicated they would pay but only at their approved amount. We were also told that the insurance certificate had changed twice, however we were never notified of any changes, nor were our employer's benefit coordinator. The current Benefits-at-a-Glance documents issued by BCBS still states that coverage for inpatient mental health care at an out-of-network provider is covered at 80% after the out-of-network deductible is reached.

The resolution we are seeking is for BCBS to pay the 80% of out-of-pocket cost after we have met our deductible as stated on the benefits-at-a-Glance document they provided.

Respondent's Argument

In the final adverse determination, BCBSM's representative explained to the Petitioner's father:

... After review, I confirmed our denial of payment must be maintained because inpatient mental health services provided by a nonparticipating inpatient facility are not a benefit of [the Petitioner's] health care plan. The non-covered charges of \$51,100.00 remain your responsibility.

³ The final adverse determination only addresses care from January 6 through May 31, 2015.

[The Petitioner] is covered under the *Community Blue Group Benefits Certificate (Certificate)*. During the course of your son's behavioral health residential psychiatric room & board services (January 6 to May 31, 2015) the *Certificate* was revised two times. According to section titled "Mental Health Services" on Page 53 of the *Certificate* revised on January 1, 2015 and Page 49 of the certificate revised on February 1, 2015:

We do not pay for:

Services provided by a nonparticipating hospital, inpatient facility or outpatient facility.

According to our records, [the Petitioner] received behavioral health residential psychiatric room & board services from January 6 to May 31, 2015 at [REDACTED]. This provider does not participate with BCBS. As a result, because your son's provider is nonparticipating, payment is not available. . . .

Finally, in your appeal letter, you specify that your provider contacted BCBS regarding mental health treatment. However, after review, I was not able to locate any record of a call made to BCBS customer service by you or your provider prior to [the Petitioner] being admitted as inpatient at [REDACTED]. . . .

Director's Review

The Petitioner's father relied on the "Benefits-at-a-Glance" summary for his understanding that at least some of the charges for the services at [REDACTED] would be covered. That summary explained that out-of-network inpatient mental health care would be covered at 80% after the out-of-network deductible had been met. But the "Benefits-at-a-Glance" summary also says:

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 exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see . . . 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, the plan document will control.

The plan document for the Petitioner's self-funded plan is the certificate. The certificate explains in more detail how benefits are paid.

The Petitioner's plan uses a "preferred provider organization" (PPO) network. Services from providers in the PPO network come with the least out-of-pocket cost. The plan will also cover certain services from out-of-network providers (i.e., non-PPO providers) but the certificate

(p. 119) says, “When you receive covered services from an out-of-network provider, BCBSM’s payment to the provider and your payment responsibilities will be determined by whether the provider is participating or nonparticipating with BCBSM.” Regarding mental health services, the certificate then goes on to say (p. 122):

BCBSM does not pay for services at nonparticipating:

* * *

- Mental health or substance abuse treatment facilities

Thus, while the plan would pay for mental health services from an out-of-network participating provider as explained in the “Benefits-at-a-Glance” summary, it does not pay for mental health services from an out-of-network nonparticipating provider like [REDACTED]

The Director concludes that the plan’s denial of coverage for the care provided by the [REDACTED] is consistent the terms and conditions of the certificate.

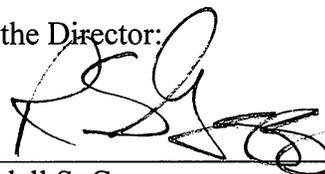
V. ORDER

The Director upholds the plan’s October 15, 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