

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. 146580-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 20<sup>th</sup> day of March 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On February 27, 2015 ██████████, on behalf of her minor son ██████████ (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 March 9, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner is enrolled for health care coverage through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information it used to make its adverse determination. BCBSM submitted the material on March 11, 2015.

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**

The Petitioner's benefits are defined in BCBSM's *Community Blue Group Benefits Certificate ASC<sup>2</sup>* (the certificate). The certificate is amended by *Rider CBC 50%-ON ASC Community Blue Coinsurance Requirement for Out-of-Network Services* (the rider). The rider increased the coinsurance requirement to 50% for most covered services from out-of-network providers.

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2 BCBSN form 457F, effective 07/14.

On October 2, 2014, the day after his birth, the Petitioner had a hearing test that is mandated by the [REDACTED] where he was born. The test (CPT code 92586) was performed by [REDACTED]. [REDACTED] does not participate with BCBSM or with a local Blue Cross and Blue Shield plan in [REDACTED] so it is considered to be out-of-network for the Petitioner's health plan.

[REDACTED] charged \$325.00. BCBSM's approved amount for the test was \$149.45 and after applying \$74.73 as the 50% out-of-network coinsurance, it paid the Petitioner \$74.72. [REDACTED] is billing the Petitioner for its entire charge of \$325.00.

The Petitioner appealed BCBSM's payment decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated January 30, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly cover the Petitioner's hearing test?

### IV. ANALYSIS

#### Petitioner's Argument

In the request for an external review, the Petitioner's mother wrote:

... My son ... was born on 10/1/2014 at [REDACTED] in [REDACTED] Hospital is an in-network hospital of BCBS Michigan. He received a state-mandated newborn hearing screening prior to discharge, which was performed by [REDACTED], an out-of-network and nonparticipating provider of BCBS Michigan. As such, BCBS is only agreeing to pay 50% of the BCBSM approved amount for a newborn screen. Please allow me to explain why I feel the service should be fully paid at the in-network rate.

The state [REDACTED] mandates a newborn hearing screening prior to discharge (i.e. if not performed, he could not be discharged from the hospital). [REDACTED] is the only group that works out of this hospital that has the equipment, personnel, and professional audiology supervision to perform the screening. They do not participate with BCBS and therefore, count as an out-of-network, nonparticipating provider. Because of the [REDACTED] mandate, my son could not have left the hospital without the screen, and without any in-network providers in the hospital, I did not have a choice of finding an in-network provider to perform the newborn screen.

According to BCBS's policies, "out-of-network services are processed as out of network unless your in-network provider refers you to an out-of-network provider." BCBS since they are unable to confirm that a valid referral was obtained prior to receiving the services in question, they are unable to honor my request for payment at the in-network rate. I think that this policy generally applies to the outpatient setting, but in the inpatient setting, rarely are there actual "referrals" but more "orders" since it's generally implicit that there is only one provider for the requested service, and not the multiple provider choices as there are in the outpatient setting. As you can see from his inpatient records enclosed (i.e. highlighted area), the newborn hearing screen was ordered by the pediatrician (the in-network provider), and showed that it was done and passed on 10/2/14. Although they did not directly give me a piece of paper for a referral to The [REDACTED] group to perform the screen, since this is the only group that performs this test in the hospital, I think it is implicit in the order that they are "referring" my son to the [REDACTED] to perform the screen in the hospital. Therefore, I feel like this should qualify as obtaining an implicit "referral" prior to receiving the services in question as requested by BCBS. If you agree, then the service should be paid at the in-network rate.

Finally, there is a discrepancy of in-network rates for various states. The specific reason that I chose BCBS Michigan PPO for my Cobra coverage was so that it would cover me in a different state as I recently moved. BCBS Michigan PPO has paid at the in-network rates for [REDACTED] for all of my other office visits and procedures. I called BCBS Michigan PPO, and they verified that for a covered in-network service, they pay at the in-network rate for the service area that the service was rendered (i.e. NJ BCBS rates), and not at the in-network rates for where the plan originated (i.e. MI BCBS rates). . . . Therefore, I think that my son's newborn screen should be paid at the in-network rate for newborn hearing screens in the state of [REDACTED] (which is higher than the in-network rate for newborn hearing screens in the state of Michigan).

If at the very least, that you do not agree the mandatory newborn hearing screen should be paid at the in-network rate, then that it should be paid at the 50% of the BCBS approved amount for a newborn screen in the state of [REDACTED].

### BCBSM's Argument

In its final adverse determination, BCBSM's representative told the Petitioner's mother:

After review, I confirmed that the claim was processed correctly. [REDACTED] [REDACTED] charged \$325.00 for the evoked potentials for audiometry testing (procedure 92586). The Blue Cross Blue Shield (BCBSM) allowed amount for this service is \$149.45, of which BCBSM paid you \$74.72. We applied \$74.73 to your out-of-network coinsurance requirement. Because . . .

████████████████████ is a nonparticipating provider, you can be billed for the charges.

You are enrolled in the University of Michigan PPO Health Care Plan. Under the terms of your coverage, as explained in the . . . *Community Group Benefits Certificate ASC, Section 2: What You Must Pay, Page 9*, payment is determined by the provider type. In-network providers agree to accept the Blue Cross Blue Shield of Michigan (BCBSM) approved amount as payment in full for covered services. Out-of-network providers, who are participating, agree to accept the BCBSM approved amount as payment in full. When the service is performed by an out-of-network and nonparticipating provider, you can be billed for the charges. Nonparticipating providers do not have a signed agreement to accept the BCBSM approved amount as payment in full.

Section 2, Page 14, of your policy explains that you are responsible for an out-of-network coinsurance requirement for services provided by out-of-network providers. This includes nonparticipating providers. *Rider CBC 50%-ON ASC Community Blue Coinsurance Requirement for Out-of-Network Services* increases the coinsurance requirement for out-of-network services to 50% of the BCBSM approved amount. This means that BCBSM pays 50% of its allowed amount, and you are responsible for the other 50%. In this instance, BCBSM paid \$74.72, leaving you responsible for \$74.73 of the \$149.45 allowed for this service.

*Rider CB-OPM-ON \$5000 ASC Community Blue Annual Out-of-Pocket Maximum for Out-of-Network Services* increases the annual out-of-pocket maximums for services by an out-of-network provider to \$10,000 for a family. On the date of service, you had not yet met the out-of-network maximum. Thus, the out-of-network coinsurance amount applies.

I understand from your appeal letter that you feel that the service should be paid at the in-network rate because the care was done at a network hospital. You can reference Page 14 of the same certificate, which explains that out-of-network services are processed as out-of-network unless your in-network provider (doctor) refers you to an out-of-network provider (doctor). Because we are unable to confirm that a valid referral was obtained before receiving the service in question, we are unable to honor your request for payment at the in-network rate.

While I understand your frustration in this situation, we are bound by the provisions of coverage. Furthermore, because the provider of the service is nonparticipating, we are unable to intervene in the balance of the billed charges. Any balance remaining for this service is a matter between you and your son's physician.

#### Director's Review

The Director concludes that BCBSM correctly processed the claim for the hearing test.

The certificate (p. 19) says BCBSM pays its “approved amount” for covered services. Approved amount is defined in the certificate (p. 140) as the

lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

To process the claim, BCBSM based its approved amount on the maximum payment level of the local Blue Cross and Blue Shield plan in [REDACTED]. The certificate (p. 123) says:

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan’s [i.e., the [REDACTED] Blue Cross and Blue Shield plan] nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services. . . .

Thus, BCBSM’s approved amount for the Petitioner’s hearing test was \$149.45, the amount the [REDACTED] Blue Cross and Blue Shield plan would have paid. Because that amount was less than the provider’s charge, it became BCBSM’s approved amount.

[REDACTED] is not a participating provider, i.e., it has not “signed a participation agreement with BCBSM to accept the approved amount as payment in full” (certificate, p. 156) and therefore can bill the Petitioner’s mother for the full amount of its charge. Also, the service is subject to the certificate’s coinsurance requirement for out-of-network providers. That coinsurance amount is set at 50% by the rider. Accordingly, BCBSM applied the 50% coinsurance to the \$149.45 (\$74.73) and then paid the Petitioner the balance (\$74.72).

The certificate (p. 118) notes the consequences of using a nonparticipating provider:

If the out-of-network provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to the subscriber. Because nonparticipating providers often charge more than our approved amount, our payment to you may be less than the amount charged by the provider.

Neither the certificate nor state law requires BCBSM to pay more than its approved amount to a nonparticipating provider, even if the Petitioner’s mother had no choice in selecting the provider.

The Petitioner's mother also argues that the hearing test should not be treated as an out-of-network service because she was referred to [REDACTED] by an in-network provider. The certificate (p. 14) says:

You will not be required to pay the [50] percent coinsurance for covered out-of-network services when:

— An in-network provider refers you to an out-of-network provider

Note: You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network coinsurance requirements.

However, there is nothing in the record to show that the Petitioner had a referral from a PPO network provider to receive services from [REDACTED]. The Petitioner's mother says that a hospital doctor ordered the test but acknowledges that "they did not directly give me a piece of paper for a referral to . . . [REDACTED] . . . to perform the screen, since this is the only group that performs this test in the hospital, I think it is implicit in the order that they are 'referring' my son to . . . [REDACTED] . . . to perform the screen in the hospital." Lacking any documentation to show that an actual referral had been made, the Director has no basis for ordering BCBSM to waive the out-of-network coinsurance requirement.

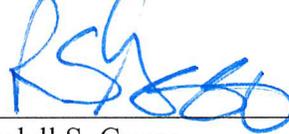
#### V. ORDER

The Director upholds BCBSM's January 30, 2015, final adverse determination.

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 in the circuit court of Ingham County. See MCL 550.1915(1). 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.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director