

**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. 148307-001**

**Blue Cross Blue Shield of Michigan**  
**Respondent**

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**Issued and entered**  
**this 7<sup>th</sup> day of July 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On June 12, 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 June 19, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits as a dependent under a small group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM), a mutual insurance company. The Director notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on June 29, 2015.

This case presents an issue of contractual interpretation. 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 health care benefits are defined in BCBSM's *Community Blue Group Group Benefits Certificate SG*. His coverage became effective August 2014. Prior to this time he had coverage through Blue Cross Blue Shield of ██████████.

On November 13, 2014, the Petitioner had blood work performed at ██████████ ██████████ in ██████████. The blood tests were ordered by a ██████████ physician. (At the time, the Petitioner was relocating from ██████████) ██████████ has 2,000 locations in the United States. The Petitioner's laboratory services were provided at the ██████████ facility in

██████████. That ██████████ laboratory participates with BCBSM but not with Blue Cross Blue Shield of ██████████. The amount charged for the laboratory services totaled \$928.54.

BCBSM processed the Petitioner's claim according to its nonparticipating provider fee schedule and paid \$56.37. This left the Petitioner responsible for \$872.17 to be paid to ██████████.

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 May 21, 2015, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly process the claim for the Petitioner's November 13, 2015 laboratory services?

### IV. ANALYSIS

#### BCBSM's Argument

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

Based on my review, I confirmed the ██████████ lab located in ██████████ is a nonparticipating provider and the payment determination is correct. Let me explain.

You are an eligible dependent covered under the *Community Blue Group Benefits Certificate* SG. This is a Preferred Provider Organization (PPO) plan. As described in the *Certificate* on page 159 a PPO is a limited group of health care providers or pharmacies who have agreed to provide covered drugs and services to BCBS members enrolled in the PPO program.

In addition, on page 141 of the *Certificate*, it describes the approved amount as the lower of the billed charge or our maximum payment level for the covered service. Any deductible and/or copayment required are subtracted from the approved amount before we make our payment.

In the *Certificate* on page 156, it explains nonparticipating providers are physicians, other health care professionals, or hospitals, and other facilities or programs that have not signed participation agreements with BCBS to accept the approved amount as payment in full. As a result, nonparticipating providers can bill you for the difference between the approved amount and their charges.

In addition, on page 142 of the *Certificate* it defines an attending physician as the physician in charge of a case who exercises overall responsibility for the patient's care in a clinic or private office setting. Also on page 141 of the *Certificate* ancillary services are described as such services as drugs, dressings, laboratory services, physical therapy or other care that supplements the care the patient receives.

In this instance, the ordering doctor (attending physician) is located in [REDACTED]. The laboratory service (ancillary service) was provided in [REDACTED]. Claims for ancillary services, such as laboratory services are reported to and processed by the BCBS plan in the state where the attending physician is located.

In addition, PPO plans are organized by state. As a result, the [REDACTED] laboratory that provided the ancillary service here in [REDACTED] cannot be a member of a [REDACTED] based PPO plan nor can it be a participating provider in [REDACTED]. The information you received from our customer service representatives regarding the processing of this claim and the status of the provider was correct. The claim was processed and BCBSM paid you the approved amount less your contractual coinsurance.

As a courtesy, I contacted Quest on your behalf. I asked Quest if they would accept 100 percent of our approved amount as payment in full. Quest declined to do so. As a result, as a nonparticipating provider, they can bill you for the difference between the approved amount and their charge.

### Petitioner's Argument

In his request for external review, the Petitioner wrote:

Our insurance just changed in August 2014 and I hadn't found a local doctor to handle my care. So the [REDACTED] doctor that I had been seeing for years issued blood work orders. (I get these every 6 months.) I went to an approved BCBSM lab to have the tests completed.

I wasn't aware that the out of state doctor would cause a coverage issue and the lab [REDACTED] didn't inform me at the time of services. These services would have been covered in the [REDACTED] or if I would have had the blood work completed while in [REDACTED]

### Director's Review

The *Community Blue* certificate provides coverage for diagnostic laboratory and pathology services. The coverage is described on page 35 of the certificate:

We pay for laboratory and pathology tests and services needed to diagnose a disease, illness, pregnancy or injury. Services must be provided:

- In a hospital (under the direction of a pathologist employed by the hospital) or
- By the patient's in-network physician or by another physician if your in-network physician refers you to one, or by an in-network laboratory at your in-network physician's direction.
  - Standard office laboratory tests approved by BCBSM performed in an in-network physician's office are payable. Other laboratory tests must be sent to an in-network laboratory.
  - You will be required to pay the out-of-network copayment if services are provided by an out-of-network laboratory or in an out-of-network hospital.

In processing this claim, BCBSM has erroneously assumed that, because the [REDACTED] laboratory does not participate with the Blue Cross Blue Shield [REDACTED], the claim should be processed as an out-of-network claim. The consequence of this assumption is that the Petitioner would be billed by [REDACTED] for \$872.17 – that portion of its charge in excess of BCBSM’s approved amount. However, [REDACTED] is a participating provider with BCBSM. Participating providers have signed agreements and agree to accept BCBSM’s approved amount as payment in full and are prohibited by this agreement from balance-billing BCBSM members. The Petitioner’s coverage is through BCBSM. He obtained services from a participating provider.

BCBSM argues that, because the doctor who ordered the tests is in [REDACTED], it must process the claims from the perspective of a [REDACTED] insurer, i.e., treat the [REDACTED] laboratory in [REDACTED] as a nonparticipating provider. This requires BCBSM to ignore the fact that the [REDACTED] lab is a participating provider with BCBSM. Treating a Michigan participating provider as a nonparticipating provider denies the insured the benefits promised in the certificate of coverage.

The Director finds that BCBSM’s payment of the Petitioner’s [REDACTED] Diagnostics Laboratory services as out-of-network is inconsistent with the terms of the Petitioner’s *Community Blue* certificate.

#### V. ORDER

The Director reverses BCBSM’s final adverse determination of May 21, 2015. BCBSM shall immediately reprocess the Petitioner’s November 13, 2014 claim on an in-network basis. BCBSM shall, within seven days of providing coverage, furnish the Director with proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 877-999-6442.

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.

Patrick M. McPharlin  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director