

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. 149213-001-SF

State of Michigan, Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

Issued and entered
this 11th day of September 2015
by Joseph A. Garcia
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On August 5, 2015,  (Petitioner), filed a request for external review with the Department of Insurance and Financial Services, appealing a claim denial issued by Blue Cross Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act" (MCL 550.1952).

On August 12, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. The Director received BCBSM's response on August 12, 2015 and additional information from BCBSM on August 19, 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 primary health care coverage is through Medicare, parts A and B. Her BCBSM/State of Michigan coverage provides secondary health care benefits which are defined in BCBSM's *State of Michigan Health Plan PPO for Medicare-Eligible Retirees Your Benefit Guide* and its *Community Blue Group Benefits Certificate ASC*. In addition, BCBSM's *Med-E-Fill ASC Medicare Exact Fill* rider augments the Petitioner's coverage to ensure that State of Michigan retirees enrolled in Medicare receive the same level of benefits as active employees.

On October 1, 2014, the Petitioner had outpatient surgery at the [REDACTED] Medical Center, a BCBSM-participating facility. The charge was \$61,783.00. Medicare applied copayment and deductible requirements and other adjustments and paid \$20,861.47.

The claim was then sent to BCBSM who determined its approved amount was \$12,084.87. After applying a 10% coinsurance of \$1,208.49, BCBSM paid \$10,876.38. (A separate claim for \$28.00 for radiology services was also submitted. Medicare determined its allowed amount was \$7.72. After applying a 20% coinsurance, it paid \$6.18. BCBSM determined its approved amount was \$1.39 and after applying a 10% coinsurance, it paid \$1.54. This left the Petitioner responsible for \$0.15 for the radiology services.)

The Petitioner appealed BCBSM's application of the deductibles through BCBSM's internal grievance process. At the conclusion of the process, BCBSM issued a final adverse determination dated July 8, 2015, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly apply deductibles to the Petitioner's October 1, 2014 surgery claim?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner wrote

The July 8, 2015 denial is wholly inadequate because, by focusing on the PPO "Benefit Guide," it ignores the essence of my appeal and what we were informed only after the surgery, i.e., that coverage was reduced from 100% to 90% on the

day of the surgery. As I explained previously...BCBSM informed my doctor's staff that the October 1 surgery was covered at 100%. Had BC timely informed us of a change in coverage, I could have scheduled the surgery earlier. BC is responsible for this negligent misrepresentation, which I relied on when I presented myself for surgery.

In a letter dated June 10, 2015, prepared for BCBSM's internal grievance, the Petitioner wrote:

I request an appeal of the incorrect decision to cover only 90% of the cost of my hospitalization during part of the day on October 1, 2014, at [REDACTED] Medical Center. That decision, which I was first informed of almost seven months later, is incorrect because, prior to my agreeing to have a spinal cord stimulator installed on that day, I asked [REDACTED] the office manager of [REDACTED] [REDACTED] who performed the surgery, to contact Blue Cross to determine whether the surgery was covered at 100%...Brenda advised me then that after she mentioned the October 1 surgery date, Blue Cross informed her that the procedure was fully covered. [REDACTED] further explained that, in the past, she had always been informed if coverage was anything other than 100%, and that she is certain that no reference was made to a lesser percentage. Had I been told at the time that coverage on or after October 1 would be at only 90%, I could have scheduled the surgery earlier.

...Assuming, for purposes of discussion only, that the information Blue Cross provided [REDACTED] was inaccurate, I should not have to pay an unnecessary bill due to the negligent representation of a Blue Cross employee.

Respondents' Argument

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

As we discussed on July 7, 2015, there are two claim decisions from October 1, 2014, that apply to your coinsurance responsibility. The claim submitted by Advanced Radiology (charge of \$28.00) was received outside the 180-day appeal request timeframe. Therefore, it did not qualify for the appeals process. Nonetheless, I reviewed that claim on an inquiry basis.

...You are covered through your husband's enrollment in the State of Michigan Health Plan PPO for Medicare-Eligible Retirees (State Health Plan PPO).

Your Benefit Guide, provided by the State Health Plan PPO, explains that Medicare is your primary coverage (Page 5). Therefore, Medicare determines whether a service is a benefit and sets the approved amount (maximum payment level) for that service (*Your Benefit Guide*, Page 5). Additionally, *Your Benefit Guide* explains that you are required to pay the deductible, coinsurance, and copayments required by the State Health Plan PPO (Page 35).

Lastly, *Your Benefit Guide* explains that we will cover 90% of the approved amount for covered outpatient hospital services (Pages 19-20). We will also cover 90% of the approved amount for radiology services and surgical services (Pages 12 and 30, *Your Benefit Guide*). For the claim from [REDACTED] Medical Center, after Medicare had made its initial payment determination, Medicare assigned to your responsibility \$12,084.87. Because as of the date of service, your BCBSM in-network deductible requirement had been met, we paid \$10,876.38 (90% of the remaining balance). We then assigned the remaining 10% to your responsibility (\$1,208.49). Because this is correct according to your Plan's guidelines, we cannot authorize additional payment.

For the claim from Advanced Radiology, after Medicare had made its initial payment determination, you were left with a remaining balance of \$1.54. We paid \$1.39, and assigned the remaining 10% to your responsibility (\$0.15). Likewise, because this is correct, we cannot authorize additional payment.

From your letter and the managerial-level conference, I understand you wish us to cover your remaining responsibility due to information you received from [REDACTED] [REDACTED] office prior to the date of service. To ensure all consideration, I contacted [REDACTED] office. I was informed that they had not been informed prior to the date of service that your coinsurance responsibility would not apply. Further, I reviewed our records, but I did not find that either you or your provider was given incorrect information prior to the date of service.

Therefore, because the claims processed correctly, we cannot approve additional payment....

Director's Review

Pages 19-20 of the *Benefit Guide* (pages 19-20) provides that BCBSM will cover 90 percent of the approved amount for covered outpatient hospital services and surgery after the deductible is met. The *Benefit Guide* (page 35) also explains the coinsurance requirement:

After you have met your deductible, you are responsible for the coinsurance, a percentage of the BCBSM allowed amount. Coinsurance is not the same as your deductible, but your supplemental plan pays the Medicare coinsurance for services covered under the State Health Plan PPO.

The Petitioner argues that BCBSM should have covered her surgery without coinsurance because her physician's office staff was advised the services would be covered at 100% and because BCBSM did not make its subscribers aware there would be a coinsurance requirement effective October 1, 2014.

Under the Patient's Right to Independent Review Act, the Director's role is limited to resolving questions of medical necessity and determining whether an insurer has properly

administered health care benefits according to the terms of the applicable policy, rider, or other applicable coverage document. See MCL 550.1911(13). The Director has no authority to amend the terms of an insurance policy to require BCBSM to provide coverage that is inconsistent with the policy's actual benefits. Consequently, the Director may not require BCBSM to provide benefits beyond those described in the *Benefit Guide* based on the Petitioner's description of what she was told by an employee of her doctor with respect to alleged statements made by BCBSM employees.

In addition, the Director observes that State of Michigan retirees were notified in a September 2014 Civil Service Commission bulletin that new coinsurance requirements would become effective October 1, 2014.

The Director finds that BCBSM processed the claims for the Petitioner's October 1, 2014 treatment in a manner consistent with the terms and conditions of her coverage.

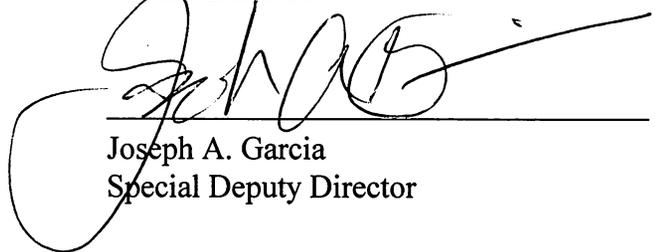
V. ORDER

The Director upholds BCBSM's final adverse determination of July 8, 2015.

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:



Joseph A. Garcia
Special Deputy Director