

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

[REDACTED]
Petitioner

v

[REDACTED] Plan Sponsor
and

Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

File No. 149625-001-SF

Issued and entered
this 23rd day of September 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On August 31, 2015, [REDACTED] (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 [REDACTED]. The plan's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC*. Two related riders establish the amounts of deductibles and copayments required.

The Petitioner's request for external review was filed under Public Act No. 495 of 2006, (Act 495) 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 Petitioner's health benefit plan is such a governmental self-funded plan. 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)

The Director accepted the Petitioner's request on September 8, 2015. The Director then notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on September 14, 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.

In this review, the Director will address only issues that can be resolved under the Patient's Right to Independent Review Act (PRIRA). The Petitioner may have other remedies outside of PRIRA for any complaints that are not dealt with in this order.

II. FACTUAL BACKGROUND

The Petitioner has rheumatoid arthritis which is treated by infusions of the drug Actemera. On April 28 and May 28, 2015, the Petitioner had the infusion therapy services performed in the outpatient department of [REDACTED] a BCBSM participating provider. Prior to April 28, the infusions were performed in her rheumatologist's office.

BCBSM approved a total of \$3,901.87 for the two dates of service then applied a deductible of \$410.13 for the April 28, 2015 service and a coinsurance charge for each date of service (\$154.80 for April 28 and \$194.38 for May 28). The Petitioner's financial obligation was \$759.31. BCBSM paid [REDACTED] \$3,142.56.

The Petitioner appealed, through BCBSM's internal grievance process, the imposition of deductible and coinsurance charges. At the conclusion of that process, BCBSM issued a final adverse determination on July 27, 2015, affirming its position. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly require the Petitioner to pay a deductible and coinsurance for her April 28, 2015 and May 28, 2015 infusion therapy services?

IV. ANALYSIS

BCBSM's Argument

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

You are covered under the *Community Blue Group Benefit Certificate ASC (Certificate)*. According to Page 44 of the *Certificate*, infusion therapy services given by a participating [BCBSM] approved infusion therapy provider are considered in-network and are subject to applicable in-network deductible and copayment requirements.

* * *

In your appeal letter, you requested that the deductible and coinsurance requirements applied to your April 28, 2015 and May 28, 2015 infusion therapy services be waived because you were incorrectly informed by a BCBSM customer service representative that your outpatient infusion therapy services would be

covered at 100 percent. However, our records show that on March 24, 2015 your provider was informed that the outpatient infusion therapy services were subject to your contractual cost share requirements.

While I regret you believe you were given incorrect information, as a Grievance and Appeals Coordinator for BCBSM, it is my responsibility to ensure that the claims at issue processed according to Plan Design. Your provider was informed prior to the date that the infusion therapy services were rendered that they would be subject to your contractual deductible and coinsurance requirements. As a result, I cannot make an exception on your behalf. Therefore, you remain liable for the cost share requirements of \$564.93 and \$194.38.

Petitioner's Argument

In her request for external review, the Petitioner wrote:

In February of this calendar year, I had become overwhelmed with the needle pokes I was receiving when I got my infusions at my rheumatologist's office. I was diagnosed with rheumatoid arthritis when I was fifteen; it has now been 18 years with this chronic illness. After countless medication trials I have landed on a particular combination that has finally given me relief. This is Actemera. I have been in the office getting infusions once a month for many years. I have driven 1.5 hours one way to get to my doctor's office for these infusions. These infusions have always been covered at 100%.

My doctor's office has one medical assistant, who is nice, but not good at starting IV's. After being poked five times per office visit to establish a patent IV line, I would leave with sore arms. Unfortunately, I was worn down and decided I should try other facilities to get my infusion at.

I did my homework prior to getting the Actemera infusions at another institute; I called and spoke with two women at BCBS to get pre authorization for my treatment before I had my outpatient infusion scheduled. I spent many hours verifying this was going to be covered at 100% using an outpatient hospital facility. I verified diagnose codes/procedure codes/facility codes, all prior to scheduling my first infusion. I was told by [REDACTED] customer service rep. at BCBS), that I have 100% coverage for this. [REDACTED] actually called [REDACTED] (the biller at [REDACTED]) to tell her the infusion was covered at 100%, so [REDACTED] would then let the scheduler schedule my appointment.

What I am asking for, is for this particular bill to be waived \$564.93 (4/28/2015) and the \$194.38 I owe for the second infusion on 5/28/2015 (prior to me having any knowledge other than this was supposed to be covered at 100%).

I have canceled my succeeding infusion appointments at the outpatient center, and have rescheduled these upcoming appointments for the doctor's office that I previously had infusions at. I am completely disappointed that I had called BCBS customer service and verified the facility code and the procedure and diagnoses codes that were used prior to my appointment on 4/28/2015, and that I was told this was covered at 100%.

In my appeals reply from BCBS, on 7/27/2015 (see attached paged three-highlighted), the reply stated "your provider was informed prior to the date..." when, in fact, this actually does nothing for backing up what the customer service representative told me. I had asked [REDACTED] the appeals rep, to review old phone conversations I had with customer service verifying that I was told I was covered at 100%. While I see the provider may have been informed, I am not sure which provider they speak of. My rheumatologist's office manager, [REDACTED] had informed me that this was covered at 100%, at the new outpatient facility: [REDACTED] and Medical Center.

...This is a substantial amount of money for me, and I had verified these procedures were to be covered before actually changing locations in which I received them. I had called multiple times to make sure this was covered, because I did not want any charges (especially when I was covered at 100% at my doctor's office).

Director's Review

Infusion therapy services are a covered benefit so long as the services are performed by a BCBSM participating provider (*Community Blue* certificate of coverage, page 44). The services do have cost sharing requirements in the form of deductibles and coinsurance. However, there are no deductibles or coinsurance for infusion services that are provided in a BCBSM network physician's office (*Community Blue* certificate of coverage, pages 10 and 12). The Petitioner's infusion services prior to April 28, 2015 were provided in her doctor's office. She then received infusion services at [REDACTED] and Medical Center. The [REDACTED] services were subject to deductible and coinsurance obligations.

The Petitioner argues that she was informed there were no cost-sharing requirements for her infusion therapy services at [REDACTED]. BCBSM asserts that her provider had been informed that there would be cost sharing requirements for the Petitioner's infusion services. Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether an insurer has properly administered health care benefits according to the terms of the applicable insurance contract and any relevant state law. The Director has no authority to amend the terms of an insurance contract based on oral statements which are inconsistent with the contract's terms.

The Director finds that BCBSM's application of deductible and coinsurances charges for the Petitioner's April 28, 2015 and May 28, 2015 infusion therapy services was consistent with the terms of her benefit plan as described in the *Community Blue* certificate and applicable riders.

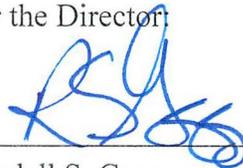
V. ORDER

The Director upholds BCBSM's July 27, 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 sixty 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