

**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. 150407-001-SF**

**State of Michigan, Plan Sponsor,**

**and**

**Blue Cross Blue Shield of Michigan, Plan Administrator,**

**Respondents.**

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**Issued and entered**  
**this 12<sup>th</sup> day of November 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) receives health care benefits through a plan sponsored by the State of Michigan (the State Health Plan or the plan), a self-funded governmental health plan subject to Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Blue Cross Blue Shield of Michigan (BCBSM) administers the plan.

In June 2015 the Petitioner was treated in the emergency room of a Texas hospital. She was dissatisfied with the amount paid for that care by the plan.

On October 19, 2015, the Petitioner filed a request with the Director of Insurance and Financial Services under Act 495 seeking an external review of the plan's payment amount. On October 26, 2015, after a preliminary review of the information submitted, the Director accepted the request.

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. BCBSM furnished the plan's response on November 2, 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.*

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 described in *Your Benefit Guide - State Health Plan PPO for Non-Medicare Eligible Retirees*<sup>1</sup> (the benefit guide).

On June 26, 2015, the Petitioner was treated by a physician in the emergency room of a hospital in ██████████, Texas. The physician was not in BCBSM's provider network nor that of a local Blue Cross or Blue Shield plan in Texas.

The charge for the physician's services was \$855.00. The plan's "allowed amount" for the care was \$267.33 and it paid that amount to the physician. The Petitioner was then billed for \$318.43, the amount in excess of BCBSM's approved amount after a discount.

The Petitioner, believing the entire charge should be paid by the plan, appealed through the plan's internal grievance process. BCBSM held a managerial-level conference and then issued a final adverse determination dated October 1, 2015, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

## III. ISSUE

Is BCBSM required to pay an additional amount for the physician services on June 26, 2015?

## IV. ANALYSIS

### Petitioner's Argument

On the external review request form the Petitioner wrote:

The problem is that when [the Petitioner] was taken to the hospital in Texas, while she was in rehab after having a seizure. The doctor in the ER was not in network and wants \$318.43 above what BCBS pays. We think that it is unreasonable to think that in an emergency setting while you are unconscious that you have the ability to find out whether the Hosp[ital] or Doctor are in network. We would like BCBS to pay the remainder of bill.

### BCBSM's Argument

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

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<sup>1</sup> Effective October 1, 2014.

. . . After review, I have determined that we have already paid the maximum benefit available for these services. No additional payment can be made. Under your family's coverage, payment for covered services is based on the approved amount, and because the provider does not participate with BCBSM, the provider may not accept our allowed amount as payment in full. The balance . . . remains a matter between you and the provider. . . .

In an e-mail dated November 2, 2015, sent in response to the external review, BCBSM also said:

It should be noted that the [*physician's*] billing statement [the Petitioner] provided . . . shows a balance due of \$318.43. It appears that the provider may have discounted their bill after the BCBSM payment of \$267.33. However, the provider is still seeking that reduced amount as they are not contractually obligated to accept the BCBSM payment as payment in full for the services.

#### Director's Review

The plan pays its "approved amount" for covered services. "Approved amount" is defined in the benefit guide (p. 51):

**Approved amount** is the BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

The plan's maximum payment level for the Petitioner's emergency room care was \$267.33. Because that amount is lower than the provider's charge of \$855.00, it became the plan's approved amount.

The plan uses BCBSM's provider network. The benefit guide (p. 36) explains how a provider's network status affects cost-sharing:

There are three levels of BCBSM provider participation. The level of a provider's participation impacts the costs for which you will be responsible. The three levels are:

- Network providers
- Non-network but participating providers
- Nonparticipating providers

The emergency room physician was a nonparticipating provider. The benefit guide (p. 36) explains the consequences of obtaining services from a nonparticipating provider:

Nonparticipating providers are providers who are not in the PPO network and do not participate in BCBSM's Traditional plan. If you receive services from a

nonparticipating provider, in addition to the out-of-network deductible and coinsurance, you may also be responsible for any charge above BCBSM's approved amount. That is because providers who do not participate with the BCBSM may choose not to accept our approved amount as payment in full for covered services. You may also be required to file your own claim.

It is unfortunate the Petitioner experienced a medical emergency and had to use a nonparticipating provider for her emergency medical treatment. However, there is nothing in the benefit guide or state law that requires the plan to pay a nonparticipating provider more than its approved amount, even in the case of an emergency or where the Petitioner had no choice. The emergency room physician is not contractually obligated to accept the plan's approved amount as payment in full and may bill the Petitioner for the difference between the charge and the plan's approved amount.

The plan paid its approved amount for the Petitioner's emergency physician services in accordance with the terms of the benefit guide.

#### V. ORDER

The Director upholds BCBSM's October 1, 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 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:



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Randall S. Gregg  
Special Deputy Director