

**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. 151937-001-SF**

**State of Michigan, Plan Sponsor,**

**and**

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

**Respondents.**

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**Issued and entered**  
this 19<sup>th</sup> day of February 2016  
by **Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) disputes the application by his health plan of a \$200.00 emergency room copayment.

On January 28, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that decision under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On February 4, 2016, after a preliminary review of the information submitted, the Director accepted the Petitioner's request.

The Petitioner receives health care benefits through a plan sponsored by the State of Michigan (the plan), a self-funded governmental health plan as defined in Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. 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. The Director received BCBSM's response on February 8, 2016.

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 the *Your Benefit Guide - State Health Plan PPO for Non-Medicare Retirees* (the benefit guide).

On October 4, 2015, the Petitioner was treated in the emergency room of a hospital in Nevada. The plan covered these services but applied a \$200.00 emergency room copayment.

The Petitioner appealed the application of the \$200.00 copayment through the plan's internal grievance process. BCBSM held a managerial-level conference and then issued a final adverse determination dated January 12, 2016, upholding the decision. The Petitioner now seeks a review of that final adverse determination from the Director.

## III. ISSUE

Was the plan correct when it applied a \$200.00 copayment to the emergency room care the Petitioner received in Nevada?

## IV. ANALYSIS

### Petitioner's Argument

In his external review request the Petitioner wrote:

On October 1, 2015 my wife and I took a trip to Las Vegas, Nevada. On [REDACTED] while at dinner at approximately 8:00 pm I experienced severe pain and swelling in my left ankle. We telephoned the two closest urgent care facilities but received an answering machine response. We then took a taxi cab to the closest hospital, Desert Springs Hospital. I underwent numerous tests, blood work and x-rays.

They were unable to determine what was causing my medical problem. They thought it was initially gout but my blood tests ruled that out. They thought it was either an infection or cellulitis. Their initial plans were to admit me that evening. I advised them that I had an early morning flight back to Michigan. They gave me medication that made the flight home more comfortable and I was advised to seek medical attention upon my return.

\* \* \*

I received a notice from Blue Cross that I owed \$200.00 for the work at Desert Springs Hospital because I was not admitted. I am appealing this charge. I had no alternative but to go to the hospital. Attempts to go to the urgent care facilities

were unsuccessful because they were closed. Desert Springs Hospital staff said they were going to admit me but changed their plan because of my flight back to Michigan within 12 hours.

. . . I should not be held accountable for the copay at Desert Springs Hospital since I had no alternative but to go to the hospital emergency room. I had no other option.

BCBSM's Argument

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

After careful review, I confirmed the claim has been processed correctly. According to the terms of your coverage, you are required to pay a \$200.00 copayment for emergency services rendered in a hospital emergency room.

You are covered by the State of Michigan Retiree State Health Plan, PPO Non-Medicare. Page 37 of Your Benefit Guide State Health Plan PPO for Non-Medicare Retirees, explains that for most covered services, you are required to pay a portion of the approved amount through deductibles, coinsurance, and copayments. Page 13, explains that your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies. Hospital services associated with the initial examination will be subject to your \$200.00 emergency room copayment. The emergency room copayment is waived only if you are admitted as inpatient

In this case, you received several covered services in the Desert Springs Hospital emergency room, but you were not admitted to the hospital. As a result, your hospital emergency room facility charges are subject to your copayment requirement. You remain responsible for the \$200.00 emergency room copayment.

During your managerial-level conference, you stated that you should not be responsible for the copayment because you had no choice other than to seek medical attention in the emergency room. You also stated that you believe the treating physicians would have admitted you if you did not have a return flight to Michigan scheduled for the early morning. I understand your position. However, your terms of coverage clearly state that when you receive covered services in a hospital emergency room and are not admitted, a \$200.00 copayment applies.

Director's Review

The benefit guide (p. 13) has this provision:

<b>Emergency care</b>	<b>\$200 copay for emergency room (waived if admitted as patient</b>
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Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies. Hospital services associated with the initial examination will be subject to your copayment.

Copayment is waived only if the patient is admitted as inpatient.

It is undisputed that the Petitioner received emergency care in the emergency room of a hospital on October 4, 2015. It is also undisputed that he was not admitted to the hospital as an inpatient. Therefore, the \$200.00 emergency room copayment applies and the Petitioner is required to pay that amount to the hospital. There is nothing in the benefit guide or in state law that requires BCBSM to waive the emergency care copayment because there was no urgent care or other lesser level of care available.

The Director concludes that BCBSM correctly applied a \$200.00 copayment to the Petitioner's emergency room care on October 4, 2015, in accord with the terms and conditions of his coverage.

#### **V. ORDER**

The Director upholds BCBSM's final adverse determination of January 12, 2016.

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:



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Randall S. Gregg  
Special Deputy Director