

**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. 152095-001-SF**

**City of Taylor, Plan Sponsor**  
**and**  
**Blue Cross Blue Shield of Michigan, Plan Administrator**  
**Respondents**

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**Issued and entered**  
**this 2<sup>nd</sup> day of March 2016**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On February 5, 2016, ██████████, authorized representative of ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review 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 City of Taylor. The benefits are described in BCBSM's *Community Blue Group Benefits Certificate LG*.

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) The Petitioner's health benefit plan is such a governmental self-funded plan.

On February 12, 2016, after a preliminary review of the information submitted, the Director accepted the request for review. The Director notified BCBSM of the appeal and asked it to provide the information used to make its final adverse determination. BCBSM furnished its response on February 22, 2016.

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 was treated at [REDACTED] on June 20, 2015. The urgent care center is a BCBSM network facility. However, the doctor who provided her care was not a BCBSM network provider. The doctor charged \$500.00. BCBSM's approved amount was \$402.90 which BCBSM applied to the Petitioner's unmet out-of-network deductible. (In this circumstance, the insured person is required to make payment directly to the provider.)

The Petitioner appealed the benefit determination through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated December 29, 2015, affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

## III. ISSUE

Did BCBSM correctly process the claim for the Petitioner's June 20, 2015, urgent care treatment?

## IV. ANALYSIS

### Petitioner's Argument

The Petitioner's authorized representative wrote in the request for external review:

[REDACTED] has both In-Network and Out-of-Network physicians. [Petitioner] made it a point to ask for an In-Network physician. She was assured that she was being seen by one. However [the doctor] was not a participating physician. We are requesting that this claim be reprocessed and applied to [Petitioner's] in-network benefits instead of out-of-network.

### Respondent's Argument

In its final adverse determination, BCBSM explained how it processed the claim for the services in question:

You are covered under the *Community Blue Group Benefits Certificate LG*. On page 8 of **Section 2: What You Must Pay**, your certificate explains that your coverage utilizes a Preferred Provider Organization (PPO) provider network, and that your payment responsibility is determined by the provider that you choose:

Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, copayment and coinsurance as payment-in-full for covered services. Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount.

On pages 9-10 of **Section 2**, your certificate explains that most covered services are subject to your deductible, with several exceptions. You are not required to pay a deductible for office visits, urgent care services, or office consultations provided by an in-network physician; rather, office and urgent care visits provided by a PPO physician are subject to a flat-rate \$10.00 copayment. However, office and urgent care visits are subject to your out-of-network deductible requirement if they are provided by a non-PPO physician.

In this case the physician who treated you was not a member of BCBSM's PPO network on the date of your urgent care visit. As a result, because your out-of-network deductible had not been satisfied on this date of service, your office visit was subject to your contractual deductible.

I do understand your frustration with this charge, in that you specifically asked to be treated by a PPO physician at Southgate Urgent Care. However, we must process claims as they are submitted by the provider and according to your physician's participation status on the date that services were rendered. You may wish to ask your provider if, under the circumstances, she would agree to accept the amount of your contractual copayment for an in-network office visit as payment in full for this service.

#### Director's Review

Based on the Petitioner's account of events, it appears that the staff of the urgent care center incorrectly told the Petitioner that her treating physician was a BCBSM in-network provider.

Because she had asked to be treated by an in-network provider, the Petitioner would like the Director to require BCBSM to process this claim as an in-network benefit. The Petitioner's in-network deductible was satisfied at the time of her urgent care treatment. By processing the claim as though the service was performed by an in-network provider, the claim would be paid by BCBSM and not allocated to the Petitioner's deductible.

However, because the urgent care doctor was a non-participating provider, the deductible must be applied to the Petitioner's non-network deductible. Under the Patient's Right to Independent Review Act, in cases that do not involve questions of medical necessity, the Director is limited to determining whether an insurer's claim decision is consistent with the terms of the relevant policy or certificate of coverage. See MCL 550.1911(13). BCBSM processed the claim for the Petitioner's June 20, 2015, physician's services in a manner consistent with the terms of the *Community Blue Group Benefits Certificate*.

**V. ORDER**

The Director upholds Blue Cross Blue Shield of Michigan's final adverse determination of December 29, 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:

A handwritten signature in black ink, appearing to read 'R. S. Gregg', is written over a horizontal line.

Randall S. Gregg  
Special Deputy Director