STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of Insurance and Financial Services

In the matter of:

[redacted]
Petitioner

v **File No. 152319-001-SF**

[redacted], Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

Issued and entered
this 15th day of March 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 22, 2016, [redacted], authorized representative of [redacted] (Petitioner), filed a request for external review with the Department of Insurance and Financial Services (DIFS), 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 Grosse Point Public Schools.

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.

The Petitioner's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC* as amended by *Rider CB-ET $100 ASC Community Blue Emergency Treatment Copayment Requirement*.

On February 29, 2016, after a preliminary review of the information submitted, the Director accepted the Petitioner's request for external review. The Director notified BCBSM of the request and asked BCBSM to provide the information used to make its final adverse

determination. BCBSM furnished its response on March 3, 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

On August 21, 2015, the Petitioner was treated at an emergency care facility in Katy, Texas, a suburb of Houston. The facility charged $5,650.00. BCBSM approved $1,320.00 and, after deducting a $100.00 copayment, paid $1,220.00. The physician who treated the Petitioner charged $790.00. BCBSM paid $166.36. The facility and the physician are not BCBSM participating providers nor do they participate with any Texas Blue Cross Blue Shield plan.

The Petitioner is now being billed by the emergency care facility for $3,430.00 – the difference between the facility's charge and the amount paid by BCBSM. (In the request for review filed with DIFS, the Petitioner did not indicate whether she has been billed by the physician.)

The Petitioner appealed the amount paid through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 8, 2016, affirming its claim processing. The Petitioner now seeks the Director's review of that determination.

III. Issue

Is BCBSM required to pay an additional amount for the Petitioner's August 21, 2015, emergency room services?

IV. Analysis

Petitioner's Argument

In the request for external review, the Petitioner's authorized representative wrote:

> [Petitioner] went to the emergency room at [redacted] in Dallas TX on 8/21/2015. It was an ***emergency*** visit at an out of network hospital. Her bill is $3,430. Because of the law, I am told by [redacted] that it should be billed ***in network.*** I have expressed this many times with BCBS on the phone, asked for the bill to be reprocessed but to no avail, there is still a balance of $3,430. I ask that you please look into this for me and process it as ***in network*** so that I am only responsible for the co-pay of $100.

In a letter dated January 21, 2016, the Petitioner wrote:

> I am writing in regards to my August 21, 2015 emergency trip to [redacted]. I went in due to severe pain and nausea that was confirmed to be stemming from a kidney stone once tests were run in the ER. While [redacted] is not an urgent care, it is an independent emergency room, which – from my understanding – is just as equipped for medical emergencies as a hospital ER. Of course, the ER referred me to a specialist who I saw later that week.
>
> I was in excruciating pain, which made the 1.5 mile drive very difficult. Since I have no family or friends living within 40 minutes of my residence, I was forced to get myself to an ER for the pain and health concerns. The pain could not wait. The closest hospital ER was three times the length of the trip and involved driving on a major Houston highway, which I did not feel comfortable with in my condition.
>
> Even though I did not know [redacted] was out of network at the time, there would have been no way for me to find something in network that was close enough for me to make the journey. The fact that I physically could not make it anywhere else for treatment and that I have been to [redacted] before and after this particular incident makes me believe that insurance should be covering the costs.

BCBSM's Argument

In the final adverse determination issued to the Petitioner's step-mother, BCBSM wrote:

> You are covered under the *Community Blue Group Benefits Certificate ASC*. As indicated on page 8, your PPO plan utilizes the Preferred Provider Organization network, which is designed to limit your out-of-pocket costs and provide the highest possible level of benefit compensation when you use physicians, hospitals, and other health care specialists that are part of the network.
>
> Page 37 of your *Certificate* states that BCBSM pays for facility and physician services to examine and treat a medical emergency or accidental injury in a hospital, participating ambulatory surgery facility, urgent care center, or physician's office. In addition, page 12 explains that you must pay a copayment for each visit for facility services in a hospital emergency room. Your *Certificate* is amended by *Rider CB-ETS100ASC Community Blue Emergency Treatment Copayment Requirement*, which states your outpatient hospital emergency room services copayment is $100.00.
>
> As described on page 134 of your *Certificate*, the BCBSM approved amount is the lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment. In this case, [Petitioner] received emergency room services from non-participating providers. BCBSM approved and paid $166.36 for the professional physician charges from Guerison Interests, LLLP. BCBSM also approved $1,320.00 for payment of the facility charges from Oneruk, Inc.; however, these charges were subject to the emergency room copayment amount of $100.00. Therefore, the amount BCBSM paid for the facility charges was $1,220.00. I have confirmed both of these claims processed as in-network claims.

> Furthermore, page 147 of your *Certificate* defines non-participating providers as physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Because Guerison Interests, LLLP and Oneruk, Inc. are non-participating providers, they may not accept the BCBSM approved amount as payment in full. The balance of the billed amounts remains a matter between you and the providers.

Director's Review

BCBSM has paid its maximum approved amount for the claims filed by the facility and the treating physician. This is the amount BCBSM would pay for an in-network claim. The approved amount is defined in the *Community Blue Group Benefits Certificate* (page 134) as

> The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

If the facility and physician had been participating providers with BCBSM or Texas Blue Cross Blue Shield, BCBSM's payment would have been accepted by the providers as payment in full. However, nonparticipating providers are not bound by any agreement with a Blue Cross Blue Shield organization to accept payment on that basis.

BCBSM has paid the maximum amount it is obligated to pay under the *Community Blue Group Benefits Certificate* and related emergency treatment rider.

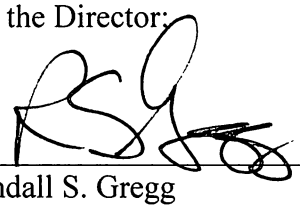
V. ORDER

The Director upholds BCBSM's final adverse determination of February 8, 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 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