

**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. 152634-001-SF**

**Wayne County Community College District, Plan Sponsor**  
**and**  
**Blue Cross Blue Shield of Michigan, Plan Administrator**  
**Respondents**

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**Issued and entered**  
**this 31<sup>st</sup> day of March 2016**  
**by Sarah Wohlford**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On March 11, 2016, ██████████ (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 Wayne County Community College District, a governmental self-funded health plan.

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.*, which 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)

On March 18, 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 appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on March 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's health care benefits are described in BCBSM's *Community Blue Group Benefit Certificate. Rider CB-ET \$250 ASC Community Blue Emergency Treatment Copayment Requirement* amends the certificate to increase the copayment requirement for emergency room services to \$250.00.

On November 14, 2015, the Petitioner received treatment in the emergency room of Beaumont Hospital Royal Oak after he developed a fever and dizziness related to cold symptoms he had been treating without success for ten days. BCBSM covered these services, but applied the \$250.00 emergency room copayment and then paid the remaining approved amount.

The Petitioner appealed the application of the \$250.00 copayment through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination dated January 13, 2016, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

## III. ISSUE

Did BCBSM correctly apply a \$250.00 copayment to the Petitioner's November 14, 2015 emergency room services?

## IV. ANALYSIS

### BCBSM's Argument

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

You are covered under the *Community Blue Group Benefits Certificate ASC*. Your certificate is amended by *Rider CB-ET \$250 ASC Community Blue Emergency Treatment Copayment Requirement*, which sets the copayment to treat a medical emergency in a hospital emergency room at \$250.00 per visit. You do not pay this copayment if you are admitted.

In this case, your treatment was provided in [REDACTED] (Royal Oak) emergency room. As a result, the service is subject to your emergency treatment copayment requirement. I understand you first sought treatment at an urgent care facility; however, you were referred to the emergency room for treatment. I also understand that you elected not to be admitted to the hospital after receiving treatment in the emergency room.

However, the claim submitted for payment reflects that treatment of a medical emergency was provided in a hospital emergency room. BCBSM must process the claim in the manner in which the provider has reported the services and we are required to administer benefits in accordance with the terms of your group Plan. As a result, I am unable to make an exception on your behalf.

### Petitioner's Argument

In his request for an external review, the Petitioner wrote:

Pertinent contract provides that there is a \$250.00 co-pay for emergency room visits. The co-pay does not apply if the patient is admitted.

Most significant facts are as set forth in [BCBSM's final adverse determination]. However, I was not referred to the emergency room. I was transported there by wheelchair through a tunnel. When offered admission, I declined for several reasons (1) there was concern that I was dizzy; I had transportation; (2) the facility seemed quite busy, and (3) I am sensitive to costs, even though I have Medicare [Part] A, and little, if any, of those costs would have been mine. In this last regard, I believe that the inability of BCBSM to read this aspect into a rather mechanical application of the contract is counter-productive.

In order to avoid dunning calls, I have now paid the \$250.00 co-pay. I request that BCBSM adjust this matter with William Beaumont Hospital and arrange a refund of \$250.00.

### Director's Review

*Rider CB-ET S250 ASC Community Blue Emergency Treatment Copayment Requirement* amended the certificate to increase the emergency room copayment to \$250.00. The copayment requirement is waived only if the patient is admitted to the hospital or if the services are required to treat an accidental injury.

In this case, the Petitioner received emergency care in the emergency room of a hospital on November 14, 2015. He was not admitted to the hospital; his treatment was not for an accidental injury. Therefore, application of the \$250.00 emergency room copayment was appropriate and the Petitioner is required to pay this amount to the hospital.

The Director finds that BCBSM's application of the \$250.00 copayment to the Petitioner's November 14, 2015 emergency room visit was consistent with the provisions of the benefit plan.

### **V. ORDER**

The Director upholds BCBSM's final adverse determination of January 13, 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:



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Sarah Wohlford  
Special Deputy Director