

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 100841-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 23rd day of February 2009
by Ken Ross
Commissioner

ORDER

I

PROCEDURAL BACKGROUND

On October 16, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on October 23, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on October 29, 2008.

The Petitioner is enrolled as an eligible dependent under his wife's health care coverage with the XXXXX, a self-funded local government group under Act 495. BCBSM administers the plan. The issue in this external review can be decided by a contractual analysis. The contract here

is BCBSM's Community Blue Group Benefits Certificate (the certificate). Rider CBC 50% NP, "Community Blue Copayment Requirement 50% for Nonpanel Services" (the rider), also applies. The Commissioner 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 underwent triple bypass surgery on December 27, 2007, in California where he resides. The surgery was performed by XXXXX, MD, a thoracic surgeon in the California medical group XXXXX.

Dr. XXXXX charged \$10,525.00 for the surgery. BCBSM's approved amount was \$2,786.81. BCBSM applied a 50% nonpanel copayment to the approved amount and paid \$1,393.41.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on July 17, 2008, and issued a final adverse determination dated August 1, 2008.

III ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's December 27, 2007, surgery?

IV ANALYSIS

Petitioner's Argument

The Petitioner says that his claim from Dr. XXXXX is being incorrectly treated as out-of-network, in spite of the fact that Dr. XXXXX participates with Blue Cross of XXXXX. The Petitioner indicates that Dr. XXXXX's billing service incorrectly filed the claim directly with BCBSM instead of through the local Blue Cross or Blue Shield plan. The Petitioner also says that BCBSM has given Dr. XXXXX's office and billing service conflicting verbal statements about the claim.

The Petitioner wants his bypass surgery to be processed as a network claim.

BCBSM's Argument

BCBSM says that page 4.2 of the certificate clearly states that BCBSM's payment is based on an "approved amount" for covered services. The certificate does not guarantee that charges will be paid in full. The approved amount is defined in the certificate as the lesser of the provider's charge or BCBSM's maximum payment level for the service. (As is customary in cases involving services performed outside of Michigan, BCBSM used the approved amount of the XXXXX Blue Cross or Blue Shield plan to determine payment because the surgery was performed in XXXXX.)

The rider provides that the Petitioner must pay 50% of the approved amount for most covered nonpanel services. The record does not establish that Dr. XXXX was a panel provider for either BCBSM or a XXXXX plan, and that is why BCBSM paid only 50% of the approved amount and applied the remaining 50% to the Petitioner's copayment as required by the rider.

During the managerial level conference, BCBSM says there was a discussion of Dr. XXXXX's participation with Blue Cross of XXXXX but not with Blue Shield of XXXXX. BCBSM believes that Dr. XXXXX is a nonparticipating provider because he billed BCBSM directly rather than the XXXXX plan.

However, as BCBSM indicated in its letter to the Petitioner dated August 1, 2008, it contacted XXXXX by telephone and spoke to the medical biller. BCBSM explained that if XXXXX participates with Blue Cross of XXXXX, the Petitioner's claim must be submitted to that plan for processing. According to BCBSM, the biller agreed to do so. BCBSM says that if and when that is done, the XXXXX plan will reimburse XXXXX at 50% of the Plan's approved amount because Dr. XXXXX is not a panel provider. The Petitioner will still be responsible for the 50% copayment of the approved amount but not for the difference between Dr. XXXXX's charge and the approved amount.

BCBSM contends that it has paid the proper amount based on how the claim is currently filed and is not required to pay more.

Commissioner's Review

The Petitioner had surgery from a provider whose participation status is indeterminate and as a result, he is being billed for a large part of the charges. He believes BCBSM should pay more than it has paid for the surgery.

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from PPO panel members or from other providers who participate with BCBSM or another Blue Cross Blue Shield plan. However, the doctor that provided the Petitioner's surgery filed the claim directly with BCBSM as if he was neither a panel nor a participating provider with a XXXXX Blue Cross or Blue Shield plan.¹ The certificate warns enrollees (page 4.27):

If the nonpanel provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial. * * *

NOTE: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate describes how benefits are paid when services are received from a nonpanel and nonparticipating provider. First, BCBSM only bases its payment "approved amount" for covered services; the certificate does not guarantee that the provider's charge will be paid in full. "Approved amount" is defined in the certificate as the BCBSM maximum payment level or the provider's charge for the covered service, whichever is lower. Second, because Dr. XXXX was not part of any Blue Cross Blue Shield PPO panel, the approved amount for his services is subject to a 50% nonpanel copayment under the rider. The rider states:

Rider CBC 50% NP amends the certificate named above to increase the member copayment requirement to 50 percent for most covered nonpanel services.

¹ Generally, a provider in another state that participates with another Blue Cross Blue Shield plan submits claims to that plan which then coordinates with BCBSM.

The amounts charged by the doctor and the amounts paid by BCBSM are shown in this table:

Procedure Code	Amount Charged by Nonpanel Physician	Approved Amount for Service	Amount Applied to Copayment	BCBSM's Payment
33535	\$9,350.00	\$2,476.40	\$1,238.20	\$1,238.20
35600	\$1,175.00	\$310.41	\$155.20	\$155.21
Totals	\$10,525.00	\$2,786.81	\$1,393.40	\$1,393.41

According to information in a letter from his office, Dr. XXXXX is a participating provider with the Blue Cross plan in XXXXX but not the Blue Shield plan in XXXXX (in XXXXX these are two separate entities). It is not shown in the record that he is a member of any BC or BS preferred provider panel and therefore the 50% copayment rider would apply to his services. Had Dr. XXXXX filed the claim with the XXXX plan as a participating provider, he would be required to accept the approved amount as payment in full. In that case the Petitioner would be responsible only for 50% of the approved amount or \$1,393.41. However, since the doctor does not participate with BCBSM, BCBSM cannot require him to accept the approved amount as payment in full. In any event, the approved amount would still be subject to the 50% nonpanel deductible.

BCBSM says it told Dr. XXXX's office that if Dr. XXXXX participates with a XXXX plan, the Petitioner's claim should first be submitted to that plan. However, nothing in the record shows that this has been done.

The Commissioner finds that the Petitioner's claim in this case was paid correctly based on the terms of his certificate, the rider, and the participation status of Dr. XXXXX. The copayment of 50% of the approved amount was correct because Dr. XXXX was not shown to be a member of any BCBS panel.

V
ORDER

BCBSM's final adverse determination of August 1, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's December 27, 2007 surgery.

This is a final decision of an administrative agency. A 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 county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.