

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. 101715-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 20th day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 2, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on December 9, 2008.

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 December 18, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Flexible Blue Group Benefits Certificate* (the certificate). *Rider Flexible Blue-D 2000/4000-P, 4000/8000-NP* and *Rider Flexible Blue-CM 1000/2000-P, 2000/4000-NP* also apply.

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

After being diagnosed with breast cancer in 2004, the Petitioner underwent a left breast mastectomy, a subsequent right breast mastectomy, and bilateral reconstruction surgery, and then had an infection of the left breast.

To correct the problems she was having with her breast reconstruction, the Petitioner sought revision of her breast reconstruction from XXXXX, MD. Dr. XXXXX removed the implants and replaced them with silicone gel prostheses. The total charge for Dr. XXXXX's surgery was \$13,094.00. BCBSM's approved \$5,072.94 for this care. Since Dr. XXXXX is not a BCBSM panel doctor, the approved amount was applied to the nonpanel deductible.

The Petitioner appealed BCBSM's decision to apply its approved amount to the nonpanel deductible, asking BCBSM to waive the nonpanel sanctions. BCBSM held a managerial-level conference on November 5, 2008, and issued a final adverse determination dated November 18, 2008.

III ISSUE

Did BCBSM correctly apply its approved amount for the Petitioner's reconstruction surgery to the nonpanel deductible?

IV ANALYSIS

Petitioner's Argument

The Petitioner was diagnosed with breast cancer and had a mastectomy in 2004. In 2005 she received permanent saline breast implants. According to the Petitioner, that was "the beginning of a nightmare." She has had multiple surgeries since 2005. She developed a hematoma in her left breast and had to wait six weeks for her body to absorb the clot. After the implant was removed and the cavity was flushed, another implant was inserted. However, this implant sat under her arm. She sought additional opinions on what to do next.

After more surgery, her breast still did not look normal and the Petitioner was at a loss at what to do next. A close friend who lives in XXXXX recommended Dr. XXXXX, a plastic surgeon. Since Dr. XXXXX was not part of the BCBSM network, the Petitioner paid for her consultation with him. Dr. XXXXX recommended going back to step one, replacing the saline implants with tissue expanders, re-expanding the tissue so that the pockets would be located where they needed to be, and then replacing the expanders with silicone implants.

The Petitioner began the surgeries with Dr. XXXXX in July 2008 and completed them in September 2008. The Petitioner said the results were amazing, that she now feels whole again. She believes that since her in-network plastic surgeon was unable to provide her with satisfactory care, that BCBSM should be required to waive the nonpanel deductible for the care provided by Dr. XXXXX.

BCBSM's Argument

BCBSM says that the certificate, in *Section 2: What You Must Pay*, states:

You are required to pay a deductible each calendar year for covered services provided by both panel and nonpanel providers.

Rider Flexible Blue –D2000/4000-P, 4000/8000-NP amends the certificate to increase the panel deductible to \$2,000.00 for one person contract and to \$4,000.00 for a family contract (two or more members), and the nonpanel deductible to \$4,000.00 for one person contract and \$8,000.00 for a family contract. The rider also allows two exceptions from the nonpanel deductible:

You will not be required to pay the nonpanel deductible for covered nonpanel services when:

- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty.

In the Petitioner's case, the deductible of \$8,000.00 applied because she has a family contract and Dr. XXXXX is not a panel provider. Therefore, the \$5,072.94 that was approved for Dr. XXXXX's surgeries was applied towards toward the required nonpanel deductible for 2008.

BCBSM says there were panel plastic surgeons available in the Petitioner's area so neither of the exceptions for the nonpanel deductible applies in her case.

BCBSM says it is sympathetic to the Petitioner for all the surgeries she had to undergo. However, it says she chose a nonparticipating provider and there are consequences for that choice of paying potential out of pocket expenses. BCBSM argues that it is not required to pay any additional amount for the Petitioner's surgery.

Commissioner's Review

The BCBSM rider *Flexible Blue-D 2000/4000-P, 4000/8000-NPCBD \$3000-NP* indicates that the Petitioner must pay an \$8,000.00 deductible each calendar year for most covered services from nonpanel providers. The rider say that the nonpanel deductible will apply unless the services fall under one of the two exceptions described above. However, in the Petitioner's case, neither of those exceptions applies.

Given the Petitioner's medical history following her diagnosis of breast cancer and her account of the unsatisfactory care she received from another plastic surgeon, the Commissioner understands why she sought care from Dr. XXXXX. However, no information was provided to show that other panel plastic surgeons were not available to her.

Under the certificate and its riders, covered services from nonpanel providers are subject to the \$8,000.00 nonpanel deductible. The Commissioner finds no basis in this record for requiring BCBSM to waive the Petitioner's nonpanel cost sharing requirements for the treatment she received from Dr. XXXXX.

V ORDER

BCBSM's final adverse determination of November 18, 2008, is upheld.

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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.