

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. 102383-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 11th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 9, 2009, XXXXX, authorized representative of 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 January 16, 2009.

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 January 28, 2009.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefits Certificate* (the certificate), the contract that defines the Petitioner's health care benefits. 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

From October 21, 2007, through December 11, 2007, the Petitioner received residential substance abuse treatment at XXXXX. The charge for this therapy was \$25,350.00.

BCBSM denied coverage for this care because XXXXX is a nonparticipating facility. The Petitioner appealed through BCBSM's internal grievance process. BCBSM held a managerial-level conference on October 21, 2008, and issued a final adverse determination dated November 10, 2008.

III ISSUE

Did BCBSM correctly deny the Petitioner's residential substance abuse treatment at XXXXX?

IV ANALYSIS

Petitioner's Argument

The Petitioner had a substance abuse problem many months prior to October 3, 2007. His father had tested him for drugs for a six month period ending in August 2007, at which time he relapsed and began taking serious illegal drugs, including heroin. He also stole money, associated with the "wrong crowd," and left home for long periods without permission.

On October 3, 2007, the Petitioner overdosed on drugs and was taken to the emergency room at XXXXX Hospital. He was diagnosed as having had a heroin overdose and released the same day. The next day he overdosed again and almost died. After treatment in the emergency room and at XXXXX he was released on October 8, 2007. The Petitioner's parents were concerned for their son's life.

According to the Petitioner's parents, they were informed by various medical personnel that XXXXX was the only facility in the U.S. that could treat him. The Petitioner's father says he called Magellan Behavioral of Michigan (Magellan), BCBSM's mental health and substance abuse

manager, and was told that treatment at XXXXX was a covered benefit. No beds were available at XXXXX for two weeks. The Petitioner's family watched over him until a bed at XXXXX became available and he was admitted on October 21, 2007.

BCBSM denied coverage for the Petitioner's care at XXXXX because it was provided at a nonparticipating facility. The Petitioner argues that the certificate language on which BCBSM based its denial only excludes outpatient care at a nonparticipating facility, and since the Petitioner was an inpatient, the language does not apply. The Petitioner says the certificate is silent with respect to inpatient substance abuse facilities.

It is also the Petitioner's position that his treatment at XXXXX was for an emergency and that BCBSM should cover emergency substance abuse treatment at a nonparticipating substance abuse facility in the same way it covers emergency care at a nonparticipating hospital.

The Petitioner believes that his care at XXXXX is a covered benefit and BCBSM is required to pay 50% of the cost or \$12,675.00.

BCBSM's Argument

BCBSM says there is no dispute that XXXXX is not a participating residential substance abuse treatment facility and therefore the Petitioner's treatment is explicitly excluded from coverage. BCBSM cites this provision relating to outpatient and residential substance abuse treatment on page 3.30 of the certificate to support its position that the Petitioner's care at XXXXX is not covered:

We pay for treatment of substance abuse in **participating** residential and outpatient substance abuse treatment programs. [Bold in original]

Page 3.52 of the certificate further states:

BCBSM does not pay for services at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, freestanding ambulatory surgery facilities, freestanding ESRD facilities, home health care agencies, hospice programs, skilled nursing facilities or for services provided by nonparticipating home infusion therapy providers. [Bold in original; underlining added]

BCBSM rejects the Petitioner's argument that the provision on page 3.52 only bars coverage

for “outpatient” mental health or substance abuse treatment facilities, not inpatient or residential facilities like XXXXX. BCBSM says the adjective “outpatient” on page 3.52 applies only to “physical therapy facilities” and not to all the other facilities mentioned in the provision. BCBSM says this interpretation is consistent with the language on page 3.30 quoted above which indicates that BCBSM only pays for substance abuse treatment in a participating facility.

BCBSM also rejects the Petitioner’s argument that his care at XXX should be handled like emergency treatment in an accredited nonparticipating hospital. BCBSM says that the Petitioner’s treatment at XXXXX was not an emergency. “Medical emergency” is defined on page 7.13 of the certificate as:

A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

After his October 8, 2007, discharge from XXXXX Hospital, the Petitioner was not treated immediately -- a period of almost two weeks passed before he was admitted to XXXXX. The treatment he received at XXXXX was not to address a medical emergency. Moreover, BCBSM says that emergency services must be provided at “an accredited nonparticipating hospital” and that XXXXX is not an accredited hospital.

BCBSM asserts that the Petitioner’s residential stay at XXXX is not a covered benefit under the certificate because the facility does not participate with any Blue Cross Blue Shield plan. BCBSM believes that the denial of coverage was correct.

Commissioner’s Review

The certificate sets forth how benefits are paid. The certificate clearly indicates that residential or outpatient substance care in a nonparticipating facility is not a covered benefit – BCBSM pays “for treatment of substance abuse in *participating* residential and outpatient substance abuse treatment programs.” No information was provided to show that Narconon participates with BCBSM or any other Blue Cross or Blue Shield plan. Since the Petitioner’s care

was provided in a nonparticipating facility it is not a covered benefit under the certificate.

Further, the Commissioner finds no basis in the record for concluding that the Petitioner received emergency services at an accredited nonparticipating hospital. The care the Petitioner received at XXXXX may have been extremely important, even essential, for his health and well-being but it does not amount to emergency care. He did not require “immediate” treatment at XXXXX; he was able to wait two weeks before he was admitted. Moreover, even if the Commissioner were to conclude that the treatment at XXXXX was for an emergency, nothing in the record establishes that XXXXX is an accredited hospital.

The Petitioner also alleged that Magellan, BCBSM’s benefit manager for mental health and substance treatment programs, led him to believe before he was admitted that his care at Narconon would be covered by BCBSM. BCBSM says it “is not able to confirm whether such a telephone call occurred.” This kind of dispute cannot be resolved in an external review under the Patient’s Right to Independent Review Act (PRIRA). The Commissioner role under PRIRA is limited to determining whether benefits have been improperly denied under the terms of the certificate and state law. Even if the Commissioner could conclude from the record that the Petitioner’s assertion is true, the Commissioner has no authority under PRIRA to order equitable relief based on such doctrines as estoppel or reliance. The circuit courts, to which PRIRA orders may be appealed, do possess that authority.

The Commissioner concludes and finds that BCBSM has denied the Petitioner’s claims correctly according to the terms and conditions of the certificate and is not required to cover the Petitioner’s residential substance abuse care at Narconon.

**V
ORDER**

BCBSM’s final adverse determination of November 10, 2008, is upheld. BCBSM is not required to cover the Petitioner’s care at Narconon.

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.