

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. 102827-001

v

Blue Cross Blue Shield of Michigan
Respondent

**Issued and entered
this 22nd day of July 2009
by Ken Ross
Commissioner**

ORDER

**I
PROCEDURAL BACKGROUND**

On February 4, 2009, 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 February 11, 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 February 17, 2009.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Flexible Blue Individual Market Certificate* (the certificate). Rider *ICB – OV, Office Visits Under the Individual Care Blue and Flexible Blue Individual Market Certificates* (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

On July 1 and July 8, 2008, the Petitioner had office visits with her physician, Dr. XXXXX, panel provider. The doctor submitted charges totaling \$280.00. BCBSM's allowed amount for this care was \$265.63 and that amount was applied to the Petitioner's 2008 panel deductible.

The Petitioner appealed BCBSM's decision to apply its allowed amount for her office visits towards her deductible. BCBSM held a managerial-level conference on January 8, 2009, and issued a final adverse determination dated January 12, 2009.

III ISSUE

Did BCBSM correctly apply its allowed amount for the Petitioner's physician office visits to her deductible?

IV ANALYSIS

Petitioner's Argument

The Petitioner is challenging BCBSM's processing of her claims for office visits on July 1 and July 8, 2008. She believes that BCBSM is required to pay its allowed amount of \$265.63 for the office visits to Dr. XXXXX.

The Petitioner states that she made multiple phone calls in June and July of 2008 regarding her coverage. She says, "I was led to believe that two office visits were covered in my policy per year. I would not have pursued these services had I believed they were not covered. I would like the tapes of these phone calls reviewed, as I believes I was misled about my coverage."

The Petitioner wants BCBSM to pay her provider and not apply the approved amounts toward her deductible.

BCBSM's Argument

BCBSM says it applied its approved amounts to the deductible based upon the terms of the certificate and the rider. BCBSM cites the following provision in the certificate (page 2.1):

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

- \$1,500 for a one-person contract
- \$3,000 for a family contract (two or more persons)

In addition, the rider amends the certificate with this provision:

The following is being added to the “Physician and Other Professional Provider Services That Are Payable” subsection of the “Coverage for Physician and Other Professional Provider Services” section of your certificate:

Office Visits

We pay our approved amount for two office visits (whether they are medically necessary or not), per member, per calendar year, when performed by a panel provider.

Office visits performed by nonpanel providers are not payable.

Note: Payment is subject to any deductible or copayment requirements of your certificate or any other riders that amend it. Also, any copayments you pay will apply to the annual copayment maximum in your certificate or any riders that amend it. * * *

BCBSM says that under the rider the Petitioner’s coverage includes two office visits per year. But the rider also says that the any deductible must be met before benefits are paid. Therefore, BCBSM applied the allowed amounts for the Petitioner’s office visits toward her unmet \$1,500 annual deductible for 2008.

BCBSM argues that it processed the Petitioner’s claims for office visits in compliance with her certificate and rider.

Commissioner’s Review

The BCBSM *Flexible Blue Individual Market Certificate* says that the Petitioner must pay a \$1,500 deductible each calendar year for most covered services from panel providers. The rider says that two office visits per calendar year are covered. However, the rider is also clear that the \$1,500 panel deductible must be met before payment is made for the office visits.

The Petitioner has not asserted or shown that the 2008 deductible of \$1,500 had been met

before the two office visits. Therefore, BCBSM correctly applied the allowed amount of \$265.63 for those visits to the deductible. If the Petitioner had already met her deductible, the allowed amount would have been paid to the Petitioner's physician.

The Petitioner contends that BCBSM misled her, informing her in telephone calls that her office visits would be payable, and that she acted in reliance on that misinformation. BCBSM acknowledges that the Petitioner called its representatives on June 30 and July 9, 2008, but says it did not mislead the Petitioner about her office visit benefits. BCBSM also says that it cannot retrieve or review those telephone calls because neither was recorded.

A resolution of the factual dispute raised by the Petitioner cannot be the basis for a decision in this case because the Patient's Right to Independent Review Act (PRIRA) does not have the hearing procedures necessary to make findings of fact based on evidence such as oral statements. Furthermore, even if it were true that BCBSM misled the Petitioner, the Commissioner cannot decide this case on that issue because under PRIRA the Commissioner does not have the authority, which circuit courts possess, to order relief based on doctrines such as reliance or estoppel. Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law.

BCBSM maintains that it processed the claims for the Petitioner's office visits in compliance with her certificate and rider and the Commissioner agrees.

V ORDER

BCBSM's final adverse determination of January 12, 2009, 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.