

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX

Petitioner

File No. 85831-001-SF

v

Blue Cross and Blue Shield of Michigan
Respondent

Issued and entered
This 5th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 22, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006, MCL550.1951 *et seq.* The Commissioner reviewed the material submitted and accepted the request on October 29, 2007. As required by section 2(2) of Act 495, the Commissioner conducts this external review according to the provisions of the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information it used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on November 1, 2007.

The issue in this external review can be decided by analyzing the BCBSM Community Blue Group Benefits Certificate (certificate), the contract defining the Petitioner's health coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). The

case does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner received outpatient mental health services from March 30 through June 25, 2007. BCBSM denied payment for this treatment. The charges in question are \$1,760.00.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on September 11, 2007, and issued a final adverse determination dated September 18, 2007, confirming its denial of coverage.

III ISSUE

Did BCBSM correctly deny coverage for the Petitioner's outpatient mental health care from March 30 through June 25, 2007?

IV ANALYSIS

Petitioner's Argument

The Petitioner stated that on April 17, 2007 she called BCBSM to inquire about her mental health benefits. She was aware that her provider, XXXXX, did not participate with insurance billing and she would be required to submit bills to BCBSM. The woman at BCBSM explained many details of the coverage including maximum life coverage amounts, 20% copays, in-network and out-of-network charges for individuals and family members, and the address to submit claims for reimbursement. The BCBSM worker knew that the Petitioner's provider was a non-participating social work therapist, and never explored the details that certain therapists must provide the services through an outpatient psychiatric facility and the requirement that such services be billed through a BCBSM approved facility.

The Petitioner argues that she called BCBSM for clarification of her benefits. She does not believe that she was given accurate information. She thought she would be responsible for a

\$250.00 deductible and a 20% copayment. She was not aware that BCBSM would not pay for any of her care since her therapist did not meet the requirements in her certificate. She feels BCBSM should pay for her outpatient mental health care based on the incorrect information that it provided to her. She wants BCBSM to pay for all her care provided by XXXXX.

BCBSM's Argument

BCBSM says the certificate specifically provides on page 4.7 that outpatient mental health care services are only payable "when provided by a physician or fully licensed psychologist in an office setting or in a participating outpatient mental health facility." In Section 7 of the certificate, "physician" is defined as "a doctor of medicine, osteopathy, podiatry, chiropractic or dentistry." BCBSM says XXXXX is a PhD and a licensed social worker and not a physician or a fully licensed psychologist as defined in the certificate. BCBSM denied coverage for the care provided by XXXXX since they did not meet the requirements set forth in the certificate.

BCBSM is aware that the Petitioner feels she was misinformed about her coverage for therapy services and that XXXXX is a great therapist and her services should be reimbursed. However, under the terms of her coverage there are limitations on who can provide outpatient mental health care and there are no exceptions.

Commissioner's Review

The certificate states that outpatient mental health care is a covered benefit when it is provided by a physician or fully licensed psychologist in the office setting or in a participating outpatient mental health facility. XXXXX is not a physician or fully licensed psychologist, and the services were not provided in a participating outpatient mental health facility. Therefore the Commissioner concludes that, while the outpatient mental health treatment provided by XXXXX may well have been effective, it does not meet the requirements of the certificate for covered outpatient mental health care.

Finally, the Petitioner indicates that BCBSM failed to inform her that care provided by a social worker not part of a BCBSM approved mental health facility was not a covered benefit. BCBSM indicated that there is a record of a telephone conversation with the Petitioner but that no misinformation was provided. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health benefits under the terms of the applicable insurance contract and state law. Resolution of a factual dispute such as the one described by the Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM correctly applied the provisions of Petitioner's certificate.

**V
ORDER**

Respondent BCBSM's final adverse determination of September 18, 2007, is upheld. BCBSM is not required to cover the outpatient mental health care provided to the Petitioner from March 30 through June 25, 2007 by XXXXX since it is not covered under the certificate.

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