

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. 113637-

001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of February 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 15, 2010, XXXXX, authorized representative of his daughter XXXXX, 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 July 22, 2010.

The Petitioner is enrolled for health care coverage through the Michigan Education Special Services Association (MESSA). The coverage is underwritten by Blue Cross and Blue Shield of Michigan (BCBSM). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. BCBSM submitted its response on August 2, 2010.

The issue in this external review can be decided by a contractual analysis. The contract here is the MESSA *Choices II Group Insurance for School Employees* (the certificate). 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 November 26, 2009, the Petitioner was treated at the emergency room of XXXXX Hospital in XXXXX for severe stomach pain. BCBSM provided coverage for this care, applying the nonpanel deductible of \$250.00 and a nonpanel copayment of \$7.40. BCBSM then paid the balance of its eligible amount of \$29.60 toward the physician care.

The Petitioner appealed BCBSM's application of the nonpanel deductible and copayment. BCBSM held a managerial-level conference on May 12, 2010, and issued a final adverse determination dated May 20, 2010.

III ISSUE

Did BCBSM pay the correct amount for the Petitioner's professional services provided on November 26, 2009?

IV ANALYSIS

Petitioner's Argument

On Thanksgiving Eve 2009, Petitioner's parents took her to the emergency room because she was in excruciating pain that caused Petitioner to double over. Her mother is a registered nurse and believed her daughter was having an appendicitis attack. She was brought to the emergency room because of the seriousness of her pain and no other outpatient facility was open on the holiday eve. Emergency room personnel eventually ruled out appendicitis but could not determine what was wrong. After multiple tests failed to pinpoint the problem, the Petitioner was told to prepare for possible exploratory surgery of the abdomen to rule out the existence of a fatty intestinal necrosis or a twisted ovary. After twenty hours of care in the hospital she was released with the diagnosis that she likely experienced a ruptured ovarian cyst. BCBSM provided coverage for the claim but applied the non-network or nonpanel deductible and copayment to the care provided by Dr. XXXXX, the physician who treated Petitioner.

The Petitioner does not understand why a deductible and copayment was applied since the care was for emergency services. The Petitioner believes that the doctor's care she received in the emergency room should be paid as in network since her condition was a medical emergency and no other outpatient facility was open at that time.

BCBSM's Argument

In its final adverse determination, BCBSM stated that the Petitioner was treated at the hospital for a genuine medical emergency. However, BCBSM insists that it appropriately applied the nonpanel \$250.00 deductible and 20% copayment to the reimbursement for the professional services provided by Dr. XXXXX. It is BCBSM's position that the waiver of the nonpanel sanctions set forth in the certificate do not apply in this case. There is no record of a referral to Dr. XXXXX from a panel provider. In addition, Dr. XXXXX did not bill BCBSM for an initial exam to treat the Petitioner's medical emergency. Rather, Dr. XXXXX billed BCBSM for one hour of critical care. Therefore, BCBSM concluded that the care provided the Petitioner does not fall into a category where the copayments and/or deductible can be waived.

Commissioner's Review

The certificate in Section 4 provides coverage for nonpanel providers with certain cost sharing requirements:

You are required to pay the following deductible each calendar year for covered services provided by nonpanel providers:

- \$250 for one member

* * *

You are required to pay the following flat dollar copayment or percentage copayment for each covered service provided by a nonpanel provider:

* * *

- 20 percent of the approved amount for most other services...

Section 4 also describes the circumstances under which the nonpanel deductible or copayment is waived:

- A panel provider refers you to a nonpanel provider
- You receive services for the initial exam to treat a medical emergency or accidental injury in the outpatient department of a hospital, urgent care

center or physician's office

The certificate defines "medical emergency" in Section 1 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.

It is clear that the Petitioner had a medical emergency. While Dr. XXXXX did not bill for an initial exam in the emergency room, she was the only doctor to treat her in the emergency room. No information was provided that any other provider billed for care for an initial exam. Therefore, Dr. XXXXX must have provided the initial exam for Petitioner's medical emergency. The Commissioner concludes that the application of the nonpanel deductible and related copayment is not consistent with the terms of Petitioner's contract.

**V
ORDER**

BCBSM's final adverse determination of May 20, 2010, is reversed. BCBSM is required to waive the \$250 deductible and \$7.40 copayment it applied to the emergency care provided Dr. XXXXX on November 26, 2009. BCBSM must provide coverage within 60 days and provide the Commissioner proof of coverage within seven days of the coverage being provided.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

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.

Ken Ross
Commissioner