

**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. 116649-001

v

Blue Cross Blue Shield of Michigan  
Respondent

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Issued and entered  
this 25th day of March 2011  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On August 26, 2010, 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 September 9, 2010.

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 September 20, 2010.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Flexible Blue Certificate* (the certificate). *Rider Flexible Blue - D 1250/2500 - P, 2500/5000 - NP* (the rider), which amends the certificate, 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

From January 4 through January 28, 2010, the Petitioner received outpatient physical therapy at XXXXX Hospital, a panel (in-network) provider. BCBSM's approved amount for the therapy was \$1,109.11 which it applied to Petitioner's \$2,500.00 panel deductible. The Petitioner believes the approved amount should have been paid to the provider and not applied to the deductible.

The Petitioner appealed BCBSM's handling of his claim. BCBSM held a managerial-level conference and then issued its final adverse determination dated August 4, 2010.

## III ISSUE

Did BCBSM correctly process the Petitioner's claim for physical therapy at XXXXX Hospital?

## IV ANALYSIS

### Petitioner's Argument

The Petitioner says the therapy department at XXXXX Hospital asked BCBSM if he was covered for therapy and that BCBSM indicated that he was. Accordingly, the therapy was increased to three times a week.

The Petitioner says that he would not have continued the physical therapy if he had known that he would be required to satisfy the deductible before BCBSM would pay anything for his care. He also believes that BCBSM should have notified the therapy department that he had not met his deductible.

The Petitioner is now being billed by XXXXX for \$1,109.11 which he says he cannot pay. The Petitioner argues that since BCBSM failed to inform the provider correctly, it should be responsible for this payment.

## BCBSM's Argument

The rider amends the "What You Must Pay" section of the certificate regarding the deductible requirement. The rider says:

### **Deductible Requirements**

We base your deductibles on amounts defined annually by the federal government for health savings account plans. Since changes in the federal government amounts will affect your deductibles, please call your customer service center for an annual update.

### Panel Providers

- \$1,250 for a one-person contract
- \$2,500 for a family contract (two or more members)

When BCBSM received the claims for the Petitioner's therapy, it applied the entire amount (\$1,109.11) to his 2010 panel deductible, which had not been met.

BCBSM says the Petitioner is not disputing the services or the amount charged. Instead, he feels that since BCBSM informed XXXXX Hospital that he had physical therapy benefits, BCBSM should also have told the hospital that his 2010 panel deductible had not yet been met.

BCBSM indicates that it has no record of a discussion with the hospital about the Petitioner's physical therapy benefit. However, even if the Petitioner's description is correct, BCBSM says it did not mislead the Petitioner or the hospital: if BCBSM were asked if the Petitioner had a physical therapy benefit and said "yes", that would be the correct response. BCBSM says that cost-sharing requirements (e.g., deductibles) are always applied before any payment is made.

BCBSM argues that it has processed the Petitioner's physical therapy benefit according to the terms and conditions of the certificate and rider.

## Commissioner's Review

The certificate and rider are clear that there is a calendar year \$2,500 family deductible for services received from panel provides. The \$1,109.11 approved for the physical therapy in January 2010 was applied to this deductible.

The Petitioner does not argue that the panel deductible had already been met. Instead, he feels that BCBSM should be responsible for paying for the physical therapy because it did not

inform XXXXX Hospital that he would be responsible out of pocket for the physical therapy because his deductible had not been met. The Commissioner disagrees.

BCBSM says it has no record of any communication with XXXXX Hospital about the Petitioner's physical therapy benefit. Even if the contact took place there is nothing in the record to indicate what was discussed or if the question of the deductible even came up. Moreover, there is no requirement in the certificate that a provider be notified of the status of a deductible.

The Petitioner was on notice that any applicable deductible had to be met before BCBSM would make a payment. The certificate (p. 2.1) says, "We [BCBSM] begin paying for services only after the total amount of the deductible has been met." Furthermore, the deductible renews each calendar year so the Petitioner knew or should have known that services provided in January, early in the calendar year, would very likely be subject to the deductible.

The Commissioner finds that BCBSM processed the claims in a manner that is consistent with both the certificate and the rider.

**V  
ORDER**

BCBSM's final adverse determination of August 4, 2010, is upheld. BCBSM is not required to pay any amount for the physical therapy provided the Petitioner from January 4 through January 28, 2010.

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.

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Ken Ross  
Commissioner