

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 113989-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 28th day of April 2011
by R. Kevin Clinton
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 21, 2010 XXXXX, authorized representative of her adult daughter 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 (PRIRA), MCL 550.1901 *et seq.*

The Petitioner receives health care benefits under Blue Cross Blue Shield of Michigan's (BCBSM) *Flexible Blue Group Benefits Certificate* (the certificate). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on August 4, 2010.

The issue in this external review can be decided by a contractual analysis. 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 September 11 through October 17, 2009, the Petitioner received residential treatment

at XXXXX in XXXXX for an eating disorder and alcohol abuse. The charge for the 36 days of care was \$106,200.00. BCBSM denied coverage. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on May 5, 2010 and issued a final adverse determination May 21, 2010.

III ISSUE

Did BCBSM correctly deny coverage for the Petitioner's care at XXXXX?

IV ANALYSIS

Petitioner's Argument

In her request for external review, Petitioner's mother wrote:

BCBS says they will not pay because services were performed at a nonparticipating facility. Our plan covers out of network. BCBS was informed on 9/2/10 that XXXXX needed residential treatment immediately. On 9/11 we had no choice but to admit her into XXXXX (recommended by her therapist). No one at BCBS would give us any information or help us in any way.

According to Petitioner, on September 2, 2009, her court-appointed internationally certified addiction counselor told the Petitioner that she needed immediate inpatient treatment of her eating disorder and alcohol abuse. A list of treatment facilities was provided by her counselor. The list included XXXXX in XXXXX. She contacted Magellan, BCBSM's agent for inpatient mental health care. Magellan had her take physicals, see doctors, and have other information sent to them. After nine days, there was no answer from BCBSM or Magellan on where she could or could not go for treatment. At no time did anyone from BCBSM provide her with the name of facilities that were approved or to tell her if XXXXX was an approved facility.

The Petitioner believed that she had an emergency that involved her mental health. Therefore, on September 11, 2009, she admitted herself to a facility recommended to her by her counselor. She argues that her insurance company let her down by ignoring her pleas for information. She expected their due diligence to be helping her. She believes that BCBSM is

required to cover her medically necessary inpatient care provided by XXXXX.

BCBSM's Argument

In its May 21, 2010 final adverse determination, BCBSM stated why coverage was denied for the Petitioner's treatment at XXXXX:

You are covered under the *Flexible Blue Individual Market* plan. Inpatient and residential treatment of eating disorders is not a contractual benefit. However, your coverage includes Case Management, a program designed to help manage the health care of members with acute or chronic condition, regardless of the setting. Case Management of eating disorders is arranged through Magellan, our mental health administrator. We have extra-contractual participation agreements with XXXXX in XXXXX for domiciliary partial hospital-level care and XXXXX in XXXXX for inpatient care. We have no such participation arrangement with XXXXX. As a result, your treatment at that facility is not a benefit, and you remain responsible for the charges.

Commissioner's Review

The Petitioner's treatment in XXXXX was provided at a residential facility that does not participate with BCBSM. The *Flexible Blue* certificate (page 3.54) provides:

BCBSM does not pay for services at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, freestanding ambulatory surgery facilities, home health care agencies, hospice programs, skilled nursing facilities or for services provided by nonparticipating home infusion therapy providers.

This provision clearly excludes coverage for treatment at XXXXX. BCBSM was willing to consider coverage for alternative treatment arrangements under the *Flexible Blue* case management program. This program, described in pages 3.49 to 3.51 of the certificate, is largely discretionary with BCBSM and requires a screening process that had not been completed before the Petitioner went to XXXXX and was admitted to XXXXX. However, the options available under the case management program would have precluded coverage for the XXXXX treatment absent a signed treatment plan (certificate, page 3.49.) No such treatment plan was ever established.

Finally, it is noted that the Petitioner believes her condition should be covered as a medical emergency. However, she received a recommendation on September 2 for treatment at XXXXX. She did not enter that facility until September 11, the day she travelled from Michigan to XXXXX.

Given the significant passage of time and her travel, the care for which she seeks coverage cannot be considered emergency treatment.

The Commissioner finds that the language in the certificate precludes coverage for the Petitioner's care at XXXXX.

**V
ORDER**

BCBSM's final adverse determination of May 21, 2010, is upheld. BCBSM is not required to cover the mental health therapy provided at XXXXX from September 11 through October 17, 2009.

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.

R. Kevin Clinton
Commissioner