

**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**

**XXXXXX**

**Petitioner**

**File No. 117613-001**

**v**

**Blue Cross Blue Shield of Michigan**  
**Respondent**

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**Issued and entered**  
**this 20th day of June 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On October 18, 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 (PRIRA), MCL 550.1901 *et seq.* The case was accepted for review on October 25, 2010.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefits Certificate* (the certificate). *Rider CBD \$1500-D Community Blue Deductible Requirement for Panel Services* 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 January 4, 2010, the Petitioner had an endoscopy. The amount charged and the amounts paid are as follows:

<b>Hospital Charges</b>	\$1,171.94
Approved Amount	\$561.34
Copayment	\$37.29
Applied to the Deductible	\$471.30
<b>Professional Charges</b>	\$550.00

Approved Amount	\$181.57
Applied to the Deductible	\$181.57
<b>Anesthesia Charges</b>	\$594.00
Approved Amount	\$390.00
Applied to the Deductible	<u>\$390.00</u>
<b>TOTAL DEDUCTIBLE APPLIED</b>	<b>\$1,042.87</b>

The Petitioner appealed the amount applied to her deductible through BCBSM's internal grievance process. On September 30, 2010, BCBSM held a managerial-level conference and on October 7, 2010, issued a final adverse determination upholding its deductible amount.

### **III. Issue**

Did BCBSM apply the correct amount to the Petitioner's deductible for her January 2, 2010 surgery?

### **IV. ANALYSIS**

#### Petitioner's Argument

The Petitioner states that her doctor suggested she have an endoscopy. Prior to the procedure, Petitioner called BCBSM to find out what her out-of-pocket costs would be. She says she was advised by a BCBSM representative that she would have no out-of-pocket costs. She was getting married on January 20, 2010, and knew the cost of this procedure would be \$75.00 on her new insurance so she decided to go ahead and have the procedure done under her BCBSM coverage without charge.

The endoscopy was performed on January 4, 2010. To her surprise, in August of 2010 she received a bill for over \$500.00. She believes that BCBSM gave her misinformation when she originally called. The Petitioner then tried to submit the expenses to her deductible reimbursement plan which she had at the time of the service, and was told it would have been covered in full but the 90 day filing period to submit a claim had expired.

Petitioner argues she would not have incurred this expense if BCBSM has just completed the paperwork in a timely manner, and given the proper information regarding her benefits prior to her surgery. Based on these facts, the Petitioner maintains BCBSM is required to reimburse the full approved amount for her January 4, 2010 surgery.

### BCBSM's Argument

Rider CBD \$1500-P amends the certificate to add the following deductibles:

#### Panel Providers

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

- \$1,500 for one member
- \$3,000 for the family (when two or more members are covered under the contract)

Petitioner's deductible in 2009 was \$1,000.00 and in 2010 it increased to \$1,500.00. She had services rendered in the fourth quarter of 2009 so a credit of \$457.13 was carried over to her 2010 deductible. Therefore, the Petitioner needed to pay \$1,042.87 to satisfy her deductible for 2010. This is the amount she was required to pay for her January 4, 2010 procedure.

As to Petitioner's claim that she was misinformed by BCBSM regarding the out-of-pocket cost of the procedure, BCBSM says it can find no evidence of Petitioner's inquiry in her claim file. BCBSM believes it correctly processed her claims per the provisions of her certificate and applicable rider and is not required to pay any additional amount.

#### Commissioner's Review

The Petitioner is required to meet a \$1,500.00 deductible before BCBSM begins to pay benefits for most services. In this case, her 2010 deductible was reduced by a carryover credit from the previous year.

The Petitioner believes that BCBSM misinformed her prior to her surgery that this care would be covered at 100%, and she would have no out-of-pocket costs. Under the 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. Resolution of the factual dispute described by Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact base on evidence such as oral statements.

The Commissioner finds that BCBSM has paid the Petitioner's January 4, 2010 claims in compliance with the language in the certificate and deductible rider.

**V. ORDER**

BCBSM's final adverse determination of October 7, 2010, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's January 4, 2010 surgery.

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 60 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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R. Kevin Clinton  
Commissioner