

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. 118028-001

v

Blue Cross Blue Shield of Michigan
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On November 10, 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 November 18, 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 November 22, 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

The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). Three riders modify the terms of the certificate:

- *CBD \$2500P* – Sets annual deductible at \$2,500.00 for one person and \$5,000.00

for a family.

- *CBC 20%P* – Requires a copayment of 20 percent of the approved amount of a claim for most covered services.
- *Community Blue Office Visit \$40* – Requires a \$40.00 copayment for office visits and office consultations.

The Petitioner was diagnosed with lymphedema in 2004. As part of his treatment for this condition he is required to wear Elvarex compression garments which, for five years, he obtained from XXXXX, a BCBSM approved medical supplier.

In 2009, when XXXXX stopped providing Petitioner with compression garments, Petitioner placed his orders through another BCBSM approved vendor, Binson's Medical Equipment. However, XXXXX's cancelled Petitioner's third order, claiming that BCBSM's payments were inadequate. Eventually, BCBSM approved and paid for his garments.

The Petitioner appealed BCBSM's handling of his claims. BCBSM held a managerial-level conference, and issued a final adverse determination dated October 20, 2010.

III. ISSUE

Is BCBSM required to pay an additional amount to the Petitioner in connection with coverage for his compression garments?

IV. ANALYSIS

Petitioner's Argument

The Petitioner says delays were caused by BCBSM. He says he was told by BCBSM that a normal doctor's prescription was not enough for his compression garments. He was required to get a letter of medical necessity and a new diagnosis from his doctor. BCBSM ignored his pleas for prompt service even after he told them what would happen if he didn't have these garments. He didn't get an adequate response from BCBSM until he was sent to therapy after complications from the lack of compression garments. Petitioner says his medical condition requires constant day and night compression on his leg. His physical work activity and active life style cause his garments to wear out. If these garments are not rotated and washed his skin will break down causing infection and increased swelling.

Finally, a BCBSM representative helped the Petitioner get coverage for the required supplies. However, this was not timely and caused him to miss work and be hospitalized. The Petitioner believes that BCBSM is required to reimburse him for the copayment he incurred for his

doctor's care and hospitalization he required because he did not have his compression garments. He also believes BCBSM is required to pay him for mileage costs to see his doctor, lost wages, and also \$50,000.00 for pain and suffering. BCBSM denied these requests.

BCBSM's Argument

Under the terms of Petitioner's certificate and riders he is required to pay a \$2,500.00 deductible and a 20% copayment for services provided by panel providers. He is also required to pay a flat dollar copayment of \$40.00 for physician office visits and consultations.

BCBSM argues that Petitioner's coverage does not include items such as lost wages, pain and suffering, or the waiver of copayments and deductibles.

BCBSM says it found no documentation that the Petitioner contacted them with any concern regarding additional garments prior to BCBSM's case manager became involved on February 23, 2010. BCBSM says its records show that it was not until March 24, 2010 that it received a prescription for the garments that explained the medical necessity for the additional garments. On April 14, 2010 Petitioner was measured for the garments which take a number of weeks to be fabricated as they are custom made in Germany. BCBSM also says that Petitioner's physical therapist notified BCBSM that he was not in compliance with his nighttime bandaging which was required until the custom fabricated garments were received.

BCBSM believes that it is not required to pay any additional amount to the Petitioner and that there are no outstanding claims to be paid in this matter.

Commissioner's Review

The certificate and applicable riders provide for deductible, copayments and limitations for medical care and equipment. There are no provisions in the certificate for the waiver of deductibles and copayments. In addition, there are no provisions for the payment of lost wages or for "pain and suffering."

Under 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 and riders. The Commissioner has no authority to order BCBSM to waive copayments and deductibles or to pay compensation for "pain and suffering." The Commissioner finds that the coverage provided by BCBSM was consistent with the provisions of the certificate and related riders.

V. ORDER

BCBSM's final adverse determination of October 20, 2010, is upheld. BCBSM is not required to pay an additional amount to the Petitioner.

This is a final decision of an administrative agency. 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. See MCL 550.1915(1), made applicable by MCL 550.1952(2). 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