

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

v

File No. 119130-001

Blue Care Network of Michigan
Respondent

Issued and entered
this 23rd day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On January 19, 2011 XXXXX, on behalf of his 17 year old son 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 Bakers receive health care benefits under the Blue Care Network of Michigan's *BCNI* certificate of coverage (the certificate). The Commissioner notified Blue Care Network (BCN) of the request for review and requested the information it used as a basis for its adverse determination. The Commissioner received BCN's response on January 21, 2011. On January 26, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's father was concerned about his son's substance abuse problem. He learned of treatment available at XXXXX of Utah. However, XXXXX is not a BCN participating provider. Petitioner was at XXXXX for 163 days, from March 28 to September 7, 2010. The cost of this care was \$61,894.00. BCN denied coverage for treatment, ruling that Petitioner did not have prior authorization to receive treatment from an out of network provider.

The Petitioner's father appealed the denial through BCN's internal grievance process and BCN affirmed its decision in its final adverse determination letter dated December 17, 2010.

III. ISSUE

Did BCN properly deny the Petitioner coverage for out of network services under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

Petitioner's father says he had great difficulty keeping his son off drugs and out of trouble. He says his final recourse was XXXXX, because his son would not seek treatment of his own accord. Petitioner's father also says he did not take into account whether or not XXXXX was a participating provider as his main concern at that time was the safety and health of his son. He says that with the assistance of XXXXX, his son is doing much better.

Respondent's Argument

In its December 17, 2010 final adverse determination, BCN wrote:

. . . Based upon the information reviewed, your request has been denied based on your BCN1 Certificate, Section 2.01, titled Unauthorized and Out-of-plan Services. There was no preauthorization, which is required, and the provider is out of network with BCN. Therefore, your request is denied to cover these services.

Commissioner's Review

Section 2.01 of the *BCN1* Schedule of Benefits, titled "Unauthorized and Out-of-Plan Services" provides:

The Health Plan is not an insurance company but a health maintenance organization which operates on a direct service basis. Health, medical, hospital, and other services

obtained by a Member outside of the Health Plan and not preauthorized by a Plan Physician are not a covered benefit under this Certificate and cannot be reimbursed to the Member or paid for by the Health Plan. . . .

The Petitioner did not have authorization from BCN to be treated at XXXXX. Preauthorization is a requirement for receiving benefits under the BCN certificate of coverage. BCN's denial of coverage was consistent with the terms and conditions of the certificate.

V. ORDER

The Commissioner upholds BCN's December 17, 2010, final adverse determination. BCN is not required to provide coverage for the out of network inpatient treatment that Petitioner received at XXXXX from March 28, 2010 through September 7, 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 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.

R. Kevin Clinton
Commissioner