

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. 118381-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 19th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On December 2, 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 December 9, 2010.

The Petitioner is enrolled for health care coverage with Blue Cross Blue Shield of Michigan (BCBSM) through an underwritten group. Her benefits are defined in the BCBSM *Community Blue Group Benefits Certificate* (the certificate). *Rider CBD \$1000-P (Community Blue Deductible Requirement For Panel Services)* and *Rider CBC 20%-P (Community Blue Copayment Requirement 20% for Panel Services)* also apply.

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 December 10, 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

On August 13, 2010, the Petitioner had an office visit with her physician who ordered several laboratory tests. Initially, BCBSM applied its allowed amount for the office visit and laboratory tests to the Petitioner's deductible. Later, BCBSM reprocessed the office visit claim to only apply the flat \$25 office visit copayment.

Petitioner's doctor submitted her blood work to XXXXX Hospital where the laboratory services were performed. The hospital charged \$1,140 for the lab work and the BCBSM approved amount was \$889.20. BCBSM applied \$815.82 to Petitioner's deductible, \$14.67 was applied to the 20% copayment, and BCBSM paid \$58.71. Petitioner believes her lab tests should have been paid by BCBSM rather than allocated to her deductible.

The Petitioner appealed BCBSM's processing of her claims. After a managerial-level conference on November 17, 2010, BCBSM did not change its position and issued a final adverse determination dated November 19, 2010.

III. ISSUE

Is BCBSM required to pay additional amounts for the Petitioner's lab tests?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states that prior to her August 13, 2010, doctor's appointment at XXXXX Hospital she called both BCBSM and the hospital to make sure both the doctor and the hospital were in her PPO provider network. She was told by both BCBSM and the doctor's office staff that both were part of the network. After her doctor's appointment, the Petitioner had lab work done. She was not concerned since she had been seen by a PPO participating provider. However, once she received her explanation of benefit form and saw the amount that was her responsibility, she made calls and was told that XXXXX Hospital codes all lab services as outpatient hospital care for which a hospital deductible applies.

The Petitioner sent her doctor's notes to BCBSM to establish that her care was a doctor's appointment and not outpatient hospital care. BCBSM agreed to pay for the doctor's claim but still applied the hospital deductible to the lab services. The Petitioner argues that, had she known the billing was done as outpatient hospital care, she could have gone to her regular clinic for the blood work.

Petitioner maintains that she was advised that her care would be provided by a PPO participating provider. She therefore believes BCBSM should pay for her lab services rather than apply the claim to her deductible.

BCBSM's Argument

Rider CBD \$1000-P amends the certificate of coverage to add an annual deductible requirement for most covered services by panel providers. The rider states in part:

Deductible requirements

Panel Providers

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

- \$1,000 for one member
- \$2,000 for the family

* * *

When a Deductible is Not Required

* * *

- Covered services performed in a panel physician's office, including presurgical consultations

* * *

BCBSM states that its records show the Petitioner did contact BCBSM prior to the services being rendered to verify that her providers were in the PPO network. BCBSM states it correctly advised her that both her doctor and the hospital are part of the PPO network. However, Petitioner did not inquire about her out-of-pocket costs. BCBSM states that the questions the Petitioner asked were answered correctly, and no misinformation was given to her.

Commissioner's Review

Rider CBD \$1000-P required Petitioner to pay a \$1,000 deductible. The rider lists services that are exempt from the \$1,000 panel deductible. The physician's visit was exempt from the panel deductible. However, the lab work was performed at the hospital and there is no exemption from the deductible for lab tests performed by a hospital. Therefore, BCBSM was correct when it applied the deductible to the laboratory services.

The Petitioner believes that BCBSM misinformed her about her benefits and misled her to believe that all her care, including the lab work, would be paid by BCBSM. BCBSM argues it did not misinform the Petitioner and all the information it provided was correct. 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 and state law. Resolution of the factual dispute described by the Petitioner cannot be part of a PRIRA decision because the PRIRA review process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM acted in compliance with the terms of the

certificate and rider when it applied a deductible to the Petitioner's laboratory tests.

V. ORDER

BCBSM's final adverse determination of November 19, 2010, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's lab tests.

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