

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. 119408-001

v

Blue Care Network of Michigan
Respondent

Issued and entered
this 25th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On February 3, 2011, 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.* On February 10, 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 contract here is the *BCN 10* certificate of coverage (the certificate). 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 has a history of pain, numbness, weakness, and swelling in the neck and shoulder. Her physician recommended she receive a special type of physical therapy, the McKenzie treatment, from Dr. XXXXX. Dr. XXXXX is not in BCN's network of providers. On November 16, 2010, Petitioner's primary care physician requested that BCN approve the out-of-network services. Prior to receiving a response, on November 17 and November 22, 2010, Petitioner proceeded with Dr. XXXXX's treatment. BCN denied coverage.

The Petitioner appealed the denial through BCN's internal grievance process. BCN maintained its denial and issued its final adverse determination January 27, 2011.

III. ISSUE

Did BCN properly deny out-of-network physical therapy visits under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states the XXXXX Clinic wanted her to receive the McKenzie treatment from Dr. XXXXX. She argues that BCN told her the physical therapy visits with Dr. XXXXX would be covered but later denied the claims. She also states that BCN's customer service department could not give her the names of any BCN providers who specialized in the services she needed so BCN should provide coverage for her visits with the out-of-network provider.

Respondent's Argument

BCN argues that its denial was in compliance with the terms of the certificate. In its January 27, 2011, final adverse determination BCN explained:

[B]ecause the provider is out of network, and because no prior authorization was obtained these services are not a covered benefit under your Certificate.

According to BCN, on November 16, 2010, Petitioner's doctor sent a referral to BCN for the out-of-network services. On November 29, 2010, the doctor's office was advised that the request had "pending" and the Petitioner was advised to check back with BCN prior to receiving services.

Commissioner's Review

BCN cited section 2.01 (page 17) of the certificate in support of its decision. Section 2.01 provides:

2.01 Unauthorized and Out-of-Plan Services

Except for emergency care as specified in Section 1.05 of this section, health, medical and hospital services listed in this Certificate are covered only if they are:

- Provided by a BCN-affiliated provider and
- Preauthorized by BCN.

Any other services will not be paid for by BCN either to the provider or to the member.

These requirements are consistent with managed care contracts. As a health maintenance organization, BCN operates within a network of providers, called participating providers, who agree to accept BCN's negotiated rates. If an HMO member uses an out-of-network provider without prior authorization and when services from participating providers are available, payment for the out-of-network provider services may be reduced or even excluded entirely.

The Petitioner asserts that BCN gave her authorization to receive treatment from Dr. XXXXX prior to the dates of service in question, but BCN denies that claim. 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 state law. Resolution of the factual dispute presented here (what may have been stated in a telephone conversation) cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds BCN's denial of coverage for the out-of-network care was consistent with the terms and conditions of the certificate.

V. ORDER

The Commissioner upholds BCN's January 27, 2011, final adverse determination. BCN is not required to provide coverage for the November 17 and November 22, 2010, physical therapy visits.

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