

**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. 119861-001**

**Blue Cross Blue Shield of Michigan**

**Respondent**

---

**Issued and entered**  
**this 12th day of August 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On March 4, 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.*

The Petitioner receives health care benefits under Blue Cross Blue Shield of Michigan's *Flexible Blue Individual Market* (the certificate). 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 March 22, 2011.

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**

Between October 14, 2008 and March 4, 2009, the Petitioner received home health care services from XXXXX, Inc., (XXXXX) a business located in XXXXX. The charge for this care was \$12,150. BCBSM denied coverage. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on January 25, 2011 and issued a final adverse determination January 26, 2011.

### **III. ISSUE**

Did BCBSM correctly deny coverage for the Petitioner's care provided by XXXXX?

### **IV. ANALYSIS**

#### Petitioner's Argument

The Petitioner indicated that XXXXX helped her receive in-home nursing care while she had a peripherally inserted central catheter (PICC) line in her arm. The nursing care included dressing changes and blood draws. The Petitioner states that XXXXX contacted BCBSM on two separate occasions to confirm that the services were covered under her insurance plan. On both occasions BCBSM confirmed coverage.

BCBSM is now denying coverage for these services because they are not covered under her insurance plan. The Petitioner appealed to BCBSM, asking for a one-time payment for these services because BCBSM gave incorrect information twice by confirming these services would be covered. The Petitioner states had she known the services were not covered, she would have made other arrangements.

#### BCBSM's Argument

BCBSM says that under the terms of the certificate it is clearly stated that coverage for home health services are payable only when the services are performed by a BCBSM participating provider. XXXXX is not a participating home health care provider.

BCBSM confirms that on September 29, 2008, it responded to a telephone inquiry about the Petitioner's home health care coverage. BCBSM states it informed the caller that Petitioner did have such coverage but did not verify that that XXXXX was a participating provider.

#### Commissioner's Review

The certificate (page 3.24) provides that home health care services must be "provided and billed by a participating home health care agency." XXXXX is not a BCBSM-participating home health care agency. The Petitioner believes BCBSM informed the provider that her home health care services were a covered benefit. BCBSM asserts that it did not misinform the provider.

Under the Patient's Right to Independent Review Act (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. The factual dispute described by the Petitioner cannot be resolved in 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 BCBSM correctly applied the provisions of the Petitioner's certificate.

**V. ORDER**

BCBSM's final adverse determination of January 26, 2011, is upheld. BCBSM is not required to cover the home health care services provided by XXXXX, Inc.

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