

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

XXXXXX

Petitioner

File No. 119972-001

v

Blue Care Network of Michigan
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On March 10, 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 Commissioner notified Blue Care Network of Michigan (BCN) of the request for external review and requested the information used in making its final adverse determination. The Commissioner received BCN's response on March 17, 2011, and after a preliminary review of the material submitted, the Commissioner accepted the request for external review. On March 28, 2011, BCN submitted additional information.

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 is a member of BCN and his health care benefits are defined in the *BCN 10* certificate of coverage (the certificate).

In November 2009, the Petitioner travelled to XXXXX and had surgery performed at XXXXX Hospital. The hospital's billing statement described the procedure as "high intensity focused ultrasound of prostate with resection of bladder neck."

XXXXX Hospital is not in BCN's network of providers. BCN denied coverage because the surgery was performed by a non-network provider without prior authorization from BCN. The Petitioner appealed the denial of coverage through BCN's internal grievance process. BCN maintained its denial and issued its final adverse determination March 1, 2011.

III. ISSUE

Did BCN properly deny coverage for Petitioner's surgery?

IV. ANALYSIS

Petitioner's Argument

Petitioner argues that the medical procedure he underwent at XXXXX Hospital could not be provided by a network provider. He states Blue Card Worldwide first approved payment and then later rescinded its offer to pay because the medical services because no prior authorization was issued by BCN.

In his February 10, 2011, appeal letter to BCN, the Petitioner wrote:

My doctor never heard of my procedure until I requested a referral to XXXXX Urology. It could not have been done in network. When a member must go out of network, they are covered around the globe.

In his appeal to OFIR, the Petitioner wrote:

Hospitalized in XXXXX. Kept overnight for observation care. Service could not be provided in network. Proof of loss submitted 12-2-09 certified mail. Instructed to resubmit certified mail to Blue Card Worldwide 1-30-10. Requested [\$]19,104.93 they approved [\$]18,972.36 for emergency services XXXXX Hospital. I am requesting [\$]19,104.93 I paid to XXXXX Hospital [for] bladder neck resection, room and overnight observation care.

Respondent's Argument

In its March 1, 2011, final adverse determination, BCN stated that the claim was denied because no prior-authorization was given and because the provider is not a part of the BCN network.

Commissioner's Review

The certificate, on page 16, describes the requirements for receiving coverage for services from out-of-network providers:

2.01 Unauthorized and Out-of-Plan Services

Except for emergency care as specified in Section 1.05 of this booklet, 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 who agree to accept BCN's negotiated rates. One purpose of the prior authorization requirement is to ensure that an HMO has the opportunity to arrange in-network care before more costly out-of-network resources are utilized. If an HMO member uses an out of network provider without prior authorization, payment for the out-of-network provider services may be greatly reduced or even excluded entirely. There is no record of any pre-surgery request for authorization and the Petitioner does not claim he contacted BCN prior to the surgery.

Under MCL, 500.3530, an HMO member may obtain services from an out-of-network provider if the HMO does not have a network provider able to perform the covered service. The record does not establish that treatment was not available within BCN's network.

Finally, there no evidence that Petitioner's surgery was emergency care. In fact, the Petitioner had planned his trip to XXXXX for the purpose of obtaining the surgery in question.

Therefore, the Commissioner finds that BCN's denial of coverage was consistent with the terms and conditions of the certificate and Michigan law.

V. ORDER

The Commissioner upholds BCN's March 1, 2011, final adverse determination. BCN is not required to provide coverage for the Petitioner's November 2009 surgery.

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