

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████,
Petitioner,

v

File No. 145418-001

Blue Cross Blue Shield of Michigan,
Respondent.

Issued and entered
this 7th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 16, 2014, ██████████, on behalf of her minor daughter ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901, *et seq.* On December 23, 2014, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on January 2, 2015.

This case presents an issue of contractual interpretation. The Director 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

The Petitioner's health care benefits are defined in BCBSM's *Simply Blue Group Benefit Certificate LG²* (the certificate). The certificate is amended by *Rider SB-OV \$40 LG Simply Blue Office Visit Copayment Requirement* and *Rider SBD-IN \$1000 / \$2000 LG Simply Blue Deductible Requirement for In-Network Services*.

¹ Born ██████████.

² BCBSM form no. 778E, approved 08/14.

On August 20, 2014, the Petitioner was seen by [REDACTED] BCBSM's approved amount for the care was \$191.09 and it applied that amount to the Petitioner's annual deductible which had not been met.

The Petitioner, believing that she should be responsible only for a \$40.00 copayment, appealed BCBSM's decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated November 13, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claim for [REDACTED] care?

IV. ANALYSIS

Petitioner's Argument

In an October 22, 2014, letter included with the external review request, the Petitioner's mother said:

I am [the Petitioner's] mother and I am appealing the \$191.09 charge for an office visit to a specialist. I am also on this insurance plan and being a type 1 diabetic see plenty of specialists and the co-pay is always \$40.00. The appointment was scheduled in advance, just like every other doctor appointment. When the appointment was made and I verified they accepted our insurance, it was made to believe this visit would also be \$40.00 and if any procedure and/or tests performed would change that charge. [The Petitioner] did not have any procedures or tests. She simply had a 15 minute office visit. When I called why it was \$191.09, I was told because they are part of a hospital and it was billed as outpatient. From what I understand, doctor's visits are outpatient visits, so again, I am confused as to why this was billed at \$191.09 and not \$40.00. If it was because of the location (offsite of the hospital, again, like all my specialists visits that are \$40.00 are as well), no one informed me this could result in a different charge. . . .

BCBSM's Argument

In its final adverse determination, BCBSM explained to the Petitioner's mother:

You are covered under the *Simply Blue Group Benefit Certificate LG and Rider SB-OV \$40 LG Simply Blue Office Visit Copayment Requirement*. That Rider amends **Section 2: What You Must Pay** of the *Certificate* to explain, you are required to pay \$40.00 for each office visit and office consultation.

In this case, procedure code 99204 . . . was reported in the hospital location. Because the visit was not reported in the physician's office location the flat-dollar

office visit copayment does not apply. Therefore, the service is subject to the deductible requirement.

* * *

The visit reported does not fall under any of the referenced requirements for waiver of the deductible. Prior to August 20, 2014 the deductible requirement had not been met. Thus, the deductible applied appropriately to the claim. The patient remains liable for the deductible amount (\$191.09).

Director's Review

The certificate, in "Section 2: What You Must Pay" (p. 9), establishes a deductible that must be met each calendar year for covered services provided by in-network providers.³ But the certificate (p. 10) also explains that not all covered services are subject to the deductible:

Your annual in-network deductible will be imposed for most covered services **except** the following:

- In-network physician office visits. (The office visit charge will be subject to a flat dollar copayment)
- Services subject to a flat-dollar copayment requirement. . . .

The certificate (p. 10) clearly says that "in-network physician office visits" are not subject to the deductible; the certificate (p. 9) further says that an "office visit and office consultation" is subject to flat-dollar copayments.⁴

The Petitioner had an office visit with [REDACTED], an in-network provider, on August 20, 2014. It was billed with CPT code 99204 which describes an office visit ("office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. . ."). A straightforward reading of the certificate and its riders supports the Petitioner's contention that only a \$40.00 copayment should apply.⁵

BCBSM says that the office visit is subject to the annual deductible because the physician's practice was part of a hospital and the claim was submitted by "a facility type of outpatient hospital." However, the Director finds nothing in the certificate that differentiates between office visits with a facility-based practice and an office visit in an unaffiliated provider's office, and BCBSM has not pointed to anything in the certificate to support its position. There is

3 *Rider SBD-IN \$1000 / \$2000 LG Simply Blue Deductible Requirement for In-Network Services* amended the certificate to establish the annual deductible at \$1,000.00 for one member or \$2,000.00 for the family.

4 The certificate (p. 10) does say that "[c]overed services performed in an in-network physician's office during an office visit will be subject to the annual deductible requirement." However, there is nothing in the record to show that any covered services were performed during the Petitioner's visit.

5 *Rider SB-OV \$40 LG Simply Blue Office Visit Copayment Requirement* establishes the copayment for each office visit or office consultation at \$40.00.

no definition of "office visit" or anything else in the certificate that explains that facility-based office visits will be treated differently for cost-sharing purposes.

The Director concludes that BCBSM incorrectly applied its approved amount for the Petitioner's office visit on August 20, 2014, to the deductible.

V. ORDER

The Director reverses BCBSM's final adverse determination of November 13, 2014.

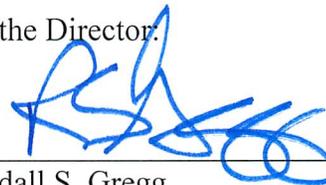
BCBSM shall, within 60 days of the date of this Order, cover the Petitioner's office visit on August 20, 2014, subject only to a \$40.00 copayment, and, within seven days of providing coverage, shall furnish the Director with proof it has complied with this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. 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 Michigan county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1). A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director