

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. 145992-001

Blue Cross Blue Shield of Michigan

Respondent

Issued and entered
this 13th day of February 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 26, 2015, ██████████, authorized representative of her husband ██████████ (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 February 3, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner is enrolled for health care coverage 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 adverse determination. BCBSM submitted the material on February 6, 2014.

The issue in this external review can be decided by a contractual analysis. 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 *Community Blue Group Benefits Certificate*¹ (the certificate).

¹ BCBSM form no. 6225, approved 10/12.

On May 7, 2014, the Petitioner received laboratory services from [REDACTED] in [REDACTED]. [REDACTED] does not participate with BCBSM or a local Blue Cross or Blue Shield plan in [REDACTED].

The charge for the services was \$200.00. BCBSM's approved amount was \$62.30, and after applying a 20% coinsurance of \$12.46, it paid the Petitioner \$49.84. This left the Petitioner responsible for paying the provider \$150.16 (\$12.46 coinsurance plus \$137.70, the difference between the provider's charge and BCBSM's approved amount).

The Petitioner appealed BCBSM's payment decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated January 6, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claim for the Petitioner's laboratory services?

IV. ANALYSIS

Petitioner's Argument

In the request for an external review, the Petitioner's wife wrote:

My husband had surgery in [REDACTED] and they sent his specimen to a lab that was out of network. We had no control over their choice. We are looking for this bill to be paid.

BCBSM's Argument

In its final adverse determination to the Petitioner's wife, BCBSM's representative said:

... My review confirmed that BCBSM has already paid the maximum benefit available under your contract. Accordingly, BCBSM sent you a check in the amount of \$49.84, representing the approved amount for the services received, less your contractual coinsurance requirement. However, because New Jersey Pathology does not participate with BCBSM, our payment to you is less than the amount charged by the provider, and you remain responsible for the balance of \$150.16.

You and [the Petitioner] are covered under the *Community Blue Group Benefits Certificate*. Payment for covered services is based on the BCBSM approved amount, which is defined in the certificate on page 7.2 of **Section 7: The**

Language of Health Care as “the lower of the billed charge or our maximum payment level for the covered services.

Further, on page 7.20 of Section 7, the certificate defines “participating providers” as:

Physicians or other health care professionals, or hospitals and other facilities or programs that have signed a participating agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Non-Participating providers have not signed such an agreement, and BCBSM is unable to compel them to accept the approved amount as full payment.

Finally, on page 4.33 of **Section 4: Coverage for Physician and Other Professional Provider Services**, the certificate explains payment of non-participating providers:

Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

I do understand your frustration with the results insofar as [the Petitioner] was not presented with an opportunity to choose his pathology provider in this instance. However, BCBSM must administer benefits in accordance with the terms of your group coverage, and I am unable to make an exception on your behalf. You may wish to contact North Jersey Pathology directly and ask whether, under the circumstances, the provider is willing to accept BCBSM’s approved amount of \$49.84 as payment in full for the services at issue.

Director’s Review

The Director has reviewed the certificate and concludes that BCBSM correctly processed the claim for laboratory services.

The certificate (p. 4.2) says BCBSM pays its “approved amount” for “diagnostic laboratory and pathology services.” “Approved amount” is defined in the certificate (p. 7.2) as the

lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

In this case, BCBSM’s maximum payment level for the laboratory services was \$62.30, which is lower than the billed charge. Laboratory services from a nonpanel (i.e., nonparticipat-

ing) provider are subject to a 20% coinsurance (certificate, p. 2.4). Thus, BCBSM was only obligated to reimburse the Petitioner for \$49.84.

BCBSM pays its approved amount to both participating and nonparticipating. However, only participating providers have agreed to accept the approved amount as payment in full for services. Nonparticipating providers may bill for the difference between their charges and BCBSM's approved amount, which was apparently the case here.

The Petitioner is understandably upset that the laboratory services were performed by a nonparticipating provider. Nevertheless, there is nothing in the certificate or in state law that requires BCBSM to pay more than its approved amount for the Petitioner's laboratory services, even when the Petitioner had "no choice" in determining the provider.

The Director finds that BCBSM's payment decision for the Petitioner's May 7, 2014, laboratory services is consistent with the terms and conditions of the Petitioner's coverage.

V. ORDER

The Director upholds BCBSM's January 6, 2014 final adverse determination.

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 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