

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

In the matter of:

██████████

Petitioner

v

Blue Cross Blue Shield of Michigan
Respondent

File No. 146248-001

Issued and entered
this 2nd day of March 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 9, 2015, ██████████ (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 17, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits under a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Petitioner's health care benefits are defined in BCBSM's *Simply Blue HRA Group Benefits Certificate* (the certificate) as amended by *Rider SB-HRA-D-P \$4000/\$8000 Simply Blue HRA Deductible Requirement for Panel Services* (the rider).

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 February 20, 2015.

This case can be resolved by applying the terms of the certificate and its related rider. The case does not require a medical opinion from an independent review organization. See MCL 550.1911(7).

II. FACTUAL BACKGROUND

In early 2014, the Petitioner's doctor prescribed physical therapy to treat pain in her left leg. Between February 20, 2014 and March 13, 2014 the Petitioner had seven physical therapy

sessions at ██████████ Hospital, a Blue Cross Blue Shield participating provider in ██████████ where the Petitioner resides. The amount charged for the therapy was \$3,236.00. BCBSM's approved amount for the therapy was \$3,171.28, which BCBSM applied to the Petitioner's annual deductible requirement.

The Petitioner appealed BCBSM's processing of the claim through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated January 30, 2015, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Was BCBSM correct in its application of the panel provider deductible to the Petitioner's 2014 physical therapy services?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination, BCBSM wrote:

You are covered under the *Simply Blue HRA Group Benefit Certificate*. **Section 4: Coverage for Physician and Other Professional Provider Services** (Page 4.15) of the certificate explains that we pay for physical therapy services when provided for rehabilitation.

Furthermore, **Section 7: The Language of Health Care** (Page 7.8) of the *Certificate* explains the following:

Deductible - The amount that you must pay for covered services, under any certificate before benefits are payable.

In addition, *Rider SB- HRA-D-P \$4,000/\$8000 Simply Blue HRA Deductible Requirement For Panel Services* amends **Section 2: What You Must Pay** (Page 2.1) of the *Certificate* to increase the annual deductible for covered services provided by panel providers for the following:

- \$4,000 for one member
- \$8,000 for the family (when two or more members are covered under your contract)

Also, the Rider indicates that your annual deductible will be imposed for most services except the following:

- Panel physician office visits
- Services subject to a flat-dollar copayment requirement
- Presurgical consultations

- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.
- Hospice care benefits

In this case, your physical therapy services do not meet the criteria referenced above to waive the panel deductible requirement that was applied to your claims. In addition, a review of our records confirmed that your panel deductible requirement was not satisfied prior to your claims being processed. In your appeal request you indicated that you contacted our customer service department prior to obtaining your services, and you were never informed that an out-of-pocket cost may apply to your claims. However, our records do not reflect a call was placed prior to your services being rendered. Therefore, because your annual deductible requirement was not satisfied prior to your claims being processed our payment determination is maintained, and you remain liable for the deductible amount applied to your claims.

Petitioner's Argument

In the request for an external review, the Petitioner wrote:

My doctor recommended physical therapy in February. I called BCBSM on 2/12/14 to verify this service was covered. I was told it was a covered procedure with no mention of a \$3,000 out-of-pocket expense. I had 7 visits of PT with the understanding they were covered/insured visits. I was billed 12/2014 \$3236.00. BCBSM representative DID NOT explain the out of pocket expense. I would have never made these appointments.

Director's Review

The rider amended the certificate to establish the family deductible for services from in-network providers at \$4,000.00 for one member and \$8,000.00 for the family. At the time the Petitioner's physical therapy claim was submitted, she had not satisfied her deductible requirement. For that reason, the approved amount for the claims (\$3,171.28) was applied to the deductible and the Petitioner was responsible for paying that amount to the provider.

The fact that the Petitioner was required to pay the deductible does not mean that BCBSM did not provide coverage for the claims; it simply meant that payment of the deductible was required before BCBSM would make any actual payments to providers. This is the normal procedure for processing claims when a BCBSM member has an unmet deductible. The procedure is described in detail in the certificate and rider. BCBSM established that the Petitioner had not met her deductible when her physical therapy claims were submitted.

Therefore, BCBSM applied its approved amount of \$3,171.28¹ for the therapy to the Petitioner's deductible.

The Director finds that BCBSM's application of its approved amount to the Petitioner's deductible was consistent with the terms of the certificate and rider.

V. ORDER

The Director upholds BCBSM's final adverse determination of January 30, 2015. BCBSM is not required to waive the Petitioner's deductible or pay for the Petitioner's physical therapy.

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

1. The Petitioner believes that she will be held responsible for \$3,236.00, the amount billed by [REDACTED] Hospital. However, because [REDACTED] Hospital is a participating provider, the maximum amount she can be charged is BCBSM's approved amount – the \$3,171.98 that was applied to her deductible.