

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. 147403-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 8th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 17, 2015, ██████████, on behalf of her minor son ██████████¹ (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 April 24, 2015, 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 immediately 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 May 5, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. See MCL 550.1911(7).

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG*.² *Rider SB-HSA-\$1750 SG Simply Blue HSA*

¹ Born December 29, 1999.

² BCBSM form no. 913F, federal approval 9/2013, state approval 08/14.

Cost-Sharing Requirements amended the certificate to increase cost-sharing requirements. The rider went into effect on December 1, 2014.

On December 2, 2014, the Petitioner received psychiatric services from the [REDACTED]. BCBSM's approved amount for those services was \$1,641.71. It applied \$958.15 of that amount to the Petitioner's annual deductible for in-network services and then paid the provider the balance of \$683.56.

The Petitioner, questioning BCBSM's decision to apply \$958.15 to the deductible, appealed through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 16, 2015, upholding its decisions. 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 psychiatric services on December 2, 2014?

IV. ANALYSIS

Petitioner's Argument

In an April 14, 2015, letter to DIFS included with the external review request, the Petitioner wrote:

It should be noted that neither the plan that was in effect from 01/01/2014 to 11/30/2014 nor the current plan requires preauthorization. However, to make absolute certain the services were covered before we proceeded we took the time to call and confirm the service codes, our deductible, and that our provider was in network. All of which the BCBS Customer Service Representative confirmed in our conversation on 11/3/2014.

In our appeal to BCBS . . . we provided documentation of our conversation with their Customer Service Representative and a follow up conversation with a CSR Supervisor who acknowledged that in review of the recorded conversation, the CSR did in fact confirm for us that the services were covered and that we had satisfied our annual deductible.

It is our contention that solely because of information provided to us during a phone call with this BCBS Customer Service Representative, a decision was made to proceed with testing for [the Petitioner] which took place on 12/2/2014 and that those services resulted in us being liable for \$958.15.

Furthermore in their appeal response dated 3/16/2015, BCBS acknowledged and offered regret that we may have received incorrect or misleading information from a BCBSM agent/ customer service representative . . . yet, they still elected to deny their responsibility for the entire bill sighting [sic] that *Rider 58-HSA- \$1750 SG Simply Blue HSA Cost-Sharing Requirements* which went in to effect on 12/1/15 [sic] and as such our deductible had not been satisfied.

How is it possible that they can acknowledge their responsibility yet deny the claim?

If as an insured; we cannot trust the very company who provides our coverage to have the most up to date and accurate information regarding our coverages, deductibles, and services where should we obtain that information?

We made a decision in good faith based on the information that BCBS provided to us. If the CSR informed us that a change was pending or as of 12/1/2014 our deductible was going to increase, we would have simply rescheduled the appointment and thus not suffered the burden of this liability.

BCBSM's Argument

In its final adverse determination, BCBSM's representative told the Petitioner's mother:

. . . After review, I have determined that we have already paid the maximum approved amount for these services and no additional payments can be made. Covered services are paid based on the approved amount. The services, as reported, are subject to your deductible. Because your deductible was not met at the time of the service, the approved amount applied to it. You are liable for the \$958.15 that applied to your deductible. Let me explain further.

You are covered under the *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG*. On page 9 of your certificate, under **Section 2: What You Must Pay**, it states that you have a deductible and coinsurance that you must pay each calendar year and that "We begin paying for services only after the total amount of the deductible has been met." In addition, page 15 of your certificate under **Section 3: What BCBSM Pays For**, states that "We pay our approved amount (see the definition of "approved amount" in Section 7) for the services you receive that are covered in this certificate and also may be covered in any riders you may have in addition to your certificate."

Page 148 of the certificate defines the approved amount 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.

Your certificate is amended by *Rider SB-HSA-\$1750 SG Simply Blue HSA Cost-Sharing Requirements*. Page 2 of the Rider amended your certificate to the following in-network cost sharing amounts: Deductible, \$3,500 for a family contract (two or more members) and Annual Out-Of-Pocket Maximum of \$12,700 for a family contract (two or more members). At the time of your son's services, you had met \$2,541.85 of your yearly \$3,500 deductible. As a result, you remain liable for the \$958.15 deductible for this service.

Director's Review

Outpatient mental health services from a network provider are a benefit under the certificate (pp. 56-57). They are also subject to a calendar year deductible for in-network services (certificate, p. 13):

Mental health services and substance abuse treatment are subject to the same annual deductible or coinsurance requirements and maximums that apply to all other in-network and out-of-network services.

The certificate (p. 9) further says that BCBSM will "begin paying for services only after the total amount of the deductible has been met." On December 1, 2014, the rider increased the family deductible (two or more members) for in-network services from \$2,600.00 to \$3,500.00 for the calendar year 2014. The Petitioner received covered mental health services on December 2, 2014; therefore those services were subject to the higher deductible.

The Director reviewed the explanation of benefit payment statements for the claims and, based on the foregoing provisions, concludes that BCBSM appropriately applied that portion of its approved amount to the deductible until the deductible was satisfied. The Director finds that BCBSM correctly processed the claims for the Petitioner's mental health services on December 2, 2014, according to the terms of his coverage on that date.

The Petitioner's mother says that she called BCBSM on November 3, 2014, and was told that the outpatient mental health services for her son were covered and that the deductible had been met.³ She contends that she relied on the information from BCBSM and scheduled the Petitioner's treatment thinking there would be no out-of-pocket expense. On the other hand, BCBSM says its notes of the telephone call say that "the member was advised a deductible would apply."

The telephone call, if it was recorded, was not submitted as part of the record so the Director does not know what was said by either the Petitioner's mother or BCBSM. But even if

³ It is undisputed that the services were a benefit under the certificate. Also, when the Petitioner's mother called BCBSM in November 2014 the family deductible for in-network services was still \$2,500.00 and may have been met.

a recording of the telephone call had been available and the Petitioner's version was accurate, it could not provide a basis for a decision. In a review under the Patient's Right to Independent Review Act (PRIRA), the Director can only determine if BCBSM properly administered benefits under the terms and conditions of the certificate and Michigan law. PRIRA does not give the Director the authority to amend the terms of an insurance contract to conform with statements made by an insurer's employees or agents.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 16, 2015.

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. 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