

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. 147495-001-SF

Farmington Board of Education, Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondent

Issued and entered
this 14th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 23, 2015, ██████████, authorized representative of his adult daughter ██████████ (Petitioner), filed a request for external review with the Department of Insurance and Financial Services, appealing four claim decisions issued by Blue Cross Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan which is sponsored by the Farmington Board of Education.

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952) The Petitioner's health benefit plan is such a governmental self-funded plan.

The plan's benefits are described in BCBSM's *Comprehensive Health Care Copayment Certificate Series CMM 10,000*. The certificate has a \$10,000.00 deductible that must be met each calendar year before BCBSM will pay benefits for any member on the contract. It also requires a 20 percent coinsurance for emergency services. Once the deductible is met, BCBSM will pay its approved amount minus any other required cost-sharing such as copayments or coinsurance.

On April 30, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on May 11, 2015.

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 is a college student in [REDACTED]. She received emergency medical treatment at [REDACTED] on four occasions: October 15, 2013; December 10, 2013; February 14, 2014; and May 27, 2014. On these dates, the Petitioner was treated by nurse practitioners employed by KY-I Medical Services which is not a participating provider with BCBSM or the [REDACTED] Blue Cross Blue Shield organization.

KY-I Medical Services billed a total of \$2,926.00. The Petitioner's coinsurance and deductibles (to be paid by the Petitioner directly to KY-I Medical Services) was \$150.93. BCBSM paid \$160.53 (this payment was issued to the Petitioner because BCBSM does not make direct payments to nonparticipating providers). KY-I Medical Services is now billing the Petitioner for that portion of its bill which remains unpaid by BCBSM or the Petitioner, approximately \$2,700.00. (The unpaid amount calculated by BCBSM differs from the amount calculated by the Petitioner's father.)

The Petitioner appealed BCBSM's payment decision through its internal grievance process. At the conclusion of that process, on February 24, 2015, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the Petitioner's claims for coverage of the KY-I Medical Services provided on October 15, 2013; December 10, 2013; February 14, 2014; and May 27, 2014?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination to the Petitioner, BCBSM wrote:

You are covered under the *Comprehensive Health Care Copayment Certificate Series CMM 10,000*. As explained in **Section 4: Coverage for Physician and Other Professional Provider Services** (Pages 4.28-4.30), nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider. When covered services are provided outside of our services area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services.

I understand that you assumed that the provider was participating because of their affiliation with the hospital; however, I confirmed that the provider, [REDACTED] I Medical Services is a nonparticipating provider. BCBSM must administer benefits in accordance with the terms of your coverage. Therefore, additional payment cannot be approved and the balance remains an issue between you and the provider.

Petitioner's Argument

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

We are seeking a re coding of the services. The bills are for the services of the doctors who saw my daughter on the four dates. The hospital has been paid because they are billing within network. The doctors are also in the network while at the emergency room where she was treated not in their private practice. We are being billed for the out of network.

Director's Review

The Petitioner's authorized representative maintains that KY-I Medical Services is a participating provider when its employees are working in a Blue Cross Blue Shield participating hospital. However, there is nothing in the certificate of coverage that mandates such a rule. The provider alone determines whether it will participate with Blue Cross Blue Shield. Neither the Director nor Blue Cross Blue Shield can require a provider to participate. Because KY-I Medical Services has not agreed to accept the Blue Cross Blue Shield approved amount as payment in full, it can bill the Petitioner for the difference between its charges and the approved amount.

The certificate does not require BCBSM to pay a nonparticipating provider's charge in full under any circumstances. As the certificate notes on page 4.28, "you should expect to pay charges to a nonparticipating provider at the time you receive the services...because non-

participating providers often charge more than our approved amount, our payment may be less than the amount charged by the provider.”

The Director finds that BCBSM correctly processed the claims for the treatment provided by KY-I Medical Services.

V. ORDER

The Director upholds BCBSM’s final adverse determination of February 24, 2015.

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 Michigan 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 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