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. 148579-001**

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 23rd day of July 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. Procedural Background

On June 29, 2015, , authorized representative of his wife (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 550.1951 *et seq*. On July 7, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through an individual plan 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 July 20, 2013.

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 benefits are defined in the *Blue Cross Premier Silver Benefits Certificate*[1] (the certificate).

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1 BCBSM form no. 603F (federal approval 11/14, state approval 02/15, effective 2015).

The Petitioner is diabetic. On March 12, 2015, while in [redacted], she purchased diabetic supplies (glucose test strips) from a Walgreens pharmacy in [redacted] Beach, an out-of-network pharmacy. The Petitioner paid Walgreens $299.97 for the supplies and then submitted a claim to BCBSM for reimbursement.

BCBSM's "approved amount" for the test strips was $156.00. BCBSM initially processed the Petitioner's claim in April 2015 as an out-of-network service and applied its entire approved amount to the Petitioner's out-of-network deductible, leaving the Petitioner responsible out of pocket for $299.97 (the $156.00 deductible plus the difference between the deductible and the provider's charge).

In July 2015 BCBSM reprocessed the claim as an in-network service.[2] It applied 20% of its approved amount ($31.20) to the Petitioner's in-network coinsurance requirement and then on July 7, 2015, sent the Petitioner a check for $124.80, the balance of the approved amount. However, because the Walgreens was an out-of-network provider, the Petitioner was still responsible out of pocket for a total of $175.17 (coinsurance of $31.20 and also the difference between Walgreens' charge and BCBSM's approved amount or $143.97).

The Petitioner appealed the BCBSM's claim processing decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated May 19, 2015, affirming its decision regarding the initial processing of the claim. The Petitioner then filed her request for an external review with the Director.

III. Issue

Did BCBSM correctly process the claim for the Petitioner's diabetic supplies?

IV. Analysis

BCBSM reprocessed the Petitioner's claim after she had requested an external review from the Director. Therefore, this review will examine the claim as it was reprocessed to determine if was correct under the terms and conditions of the certificate.

The Petitioner's health plan is a preferred provider organization (PPO) plan that encourages health care services to be obtained from in-network providers. The certificate (p. 10) says:

> You have PPO coverage under this certificate. PPO coverage uses a "Preferred Provider Organization" provider network. What you must pay depends on the

2 See explanation of benefit payment statement dated July 7, 2015.

> type of provider you choose. If you choose an "in-network" provider, you most often pay less money than if you choose an "out-of-network" provider.

The Petitioner purchased her diabetic supplies from Walgreens. Walgreens is out of network for the Petitioner's PPO plan which means the Petitioner could be subject to sanctions for using an out-of-network provider.

The certificate (p. 18) explains how BCBSM calculates its payment for services:

> We pay our approved amount . . . for the services you receive that are covered in this certificate and in any riders you may have in addition to your certificate.

"Approved amount" is defined in the certificate (p. 151) as

> [t]he 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.

When the Petitioner submitted the claim for the diabetic supplies, BCBSM determined that its maximum payment level was $156.00. Because that amount was lower than the provider's charge, it became the approved amount and the basis for BCBSM's payment. The certificate does not require BCBSM to pay more than its approved amount for a covered service.

Even though Walgreens is out of network, BCBSM reprocessed the claim as though Walgreens was in-network. Regarding in-network coinsurance, the certificate says (p. 13):

> Unless stated otherwise, after your in-network or out-of-network deductible has been met, you are required to pay a coinsurance for most covered services.
>
> **In-Network Coinsurance**
>
> Your coinsurance for most services provided by in-network providers is 20 percent after the in-network deductible is paid.

The certificate does not exempt diabetic supplies from the 20% coinsurance requirement[3] and the explanation of benefit payments statement dated July 7, 2015, indicates that the Petitioner had met her in-network deductible at the time the claim was reprocessed in July 2015. Therefore, BCBSM applied 20% coinsurance to its approved amount (20% of $156.00 = $31.20) and then reimbursed the Petitioner $124.80.

If Walgreens had been an in-network provider, it would have accepted $156.00 as payment in full for the diabetic supplies (certificate, p. 10). But, according to the explanation of benefit payments statement dated July 7, 2015, Walgreens is not only not in-network it is a non-participating provider. The certificate (p. 10) has this notice: "Nonparticipating providers have

3 They are exempt from the 50% coinsurance requirement for durable medical equipment (certificate, p. 11).

not signed an agreement and can bill you for any differences between their charges and our approved amount." Consequently, the Petitioner is responsible for the difference between BCBSM's approved amount and Walgreens' charge.

The Petitioner raised several arguments in her extern review request that were resolved when BCBSM reprocessed the claim. But the fact remains that the diabetic supplies were purchased from an out-of-network, nonparticipating provider and that has meant that the Petitioner had more out-of-pocket costs than if she had gone to an approved provider.

Based on the foregoing, the Director concludes and finds that BCBSM correctly reprocessed the claim for diabetic supplies.

V. ORDER

The Director upholds BCBSM's reprocessing of the Petitioner's claim for reimbursement for diabetic supplies.

This is a final decision of an administrative agency. Any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the Michigan county where the covered person resides or 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.

Patrick M. McPharlin
Director

For the Director:

Randall S. Gregg
Special Deputy Director