

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. 148802-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 4th day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 14, 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.* After a preliminary review of the information submitted, the Director accepted the Petitioner's request on July 21, 2015.

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 30, 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.

In this review, the Director will address only issues that can be resolved under the Patient's Right to Independent Review Act (PRIRA). The Petitioner may have other remedies outside of PRIRA for any complaints that are not dealt with in this Order.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the *Blue Cross Premier Bronze Extra Benefits Certificate*¹ (the certificate).

¹ BCBSM form no. 820H; federal approval 11/14 and state approval 02/15; effective 2015.

On March 25, 2015, the Petitioner had a gynecological examination, including tests for human papillomavirus and cervical cancer. The samples taken during the examination were sent to an out-of-state laboratory for processing and interpretation.

The charge for the laboratory services was \$404.00. BCBSM denied coverage because the laboratory is a non-network provider, i.e., it has no contracted to provide services for the Petitioner's health plan.

The Petitioner appealed the denial through BCBSM's internal grievance process. On June 10, 2015, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Was BCBSM correct in denying coverage for the Petitioner's laboratory and pathology tests?

IV. ANALYSIS

Petitioner's Argument

In a July 7, 2015, letter submitted for this external review, the Petitioner wrote:

. . . I had an annual well woman examination on March 25, 2015. . . . At that time I had seen in my booklet that my annual gynecologic exam would be 100% covered as a preventative care visit. I had therefore thought this was completely covered.

I later received a bill from [a laboratory] in [REDACTED] for the cost of running the pathology and lab tests. I had not been aware that my tests would be sent out of state for analysis, nor that it would not be covered at another facility associated with the one I went to.

I later found out from my provider that the reason these were sent to Wausau is because there is no closer affiliated site that can process the results in under 2 hours.

Please reconsider my appeal. Had I been aware that my samples would be sent to a facility where my insurance is not covered I would have either requested to have them sent elsewhere, or I would chosen [*sic*] not to get the exam.

Respondent's Argument

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

. . . After review, I determined that [the laboratory] is a nonparticipating provider and that the denial of payment is appropriate. You remain liable for the non-covered charges totaling \$404.00.

You are covered by the *Blue Cross Premier Bronze Extra Benefits Certificate (Certificate)*. According to Page 90 of the *Certificate*, we pay 100 percent of our approved amount for these preventive care services: Health Maintenance Examination, Flexible Sigmoidoscopy, Gynecological Examination, Screening Mammography, Fecal Occult Blood Screening. . . .

However, your health care plan limits payment for the rendering, reading and interpretation of preventative services at 100 percent only when those services are rendered by an in-network provider. . . .

Director's Review

The Petitioner's gynecological examination and related tests are covered benefits. But the certificate (p. 90) says the services must be done by in-network providers:

We pay for:

We pay 100% of our approved amount for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by in-network providers.

Deductibles, coinsurance or copayments are not required for these services when performed by an in-network provider.

* * *

- Gynecological Examination

One routine gynecological examination per member, per calendar year.

Since the laboratory that performed the tests is not an in-network provider, BCBSM was correct when it denied coverage, and on that basis the Director upholds BCBSM's final adverse determination.

The Petitioner's fundamental complaint is that she did not know that the samples would be sent to an out-of-network provider and therefore had no opportunity to ask that the test be performed by an in-network provider. As a result, she is left with high out-of-pocket costs she did not expect.

Unfortunately, that complaint cannot be addressed under the Patient's Right to Independent Review Act. In this review, the Director can only determine if BCBSM correctly applied the language of the certificate of coverage. The Director does not have the authority to alter the terms and conditions of the Petitioner's coverage under the circumstances in this case.

V. ORDER

The Director upholds BCBSM's June 10, 2015 final adverse determination.

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.

Patrick M. McPharlin
Director

For the Director:

A handwritten signature in black ink, appearing to read 'R. S. Gregg', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director