

**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. 148871-001**

**Blue Cross Blue Shield of Michigan,**

**Respondent.**

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**Issued and entered**  
**this 10<sup>th</sup> day of August 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On July 20, 2015, ██████████ 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 request on July 27, 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 request and asked for the information used to make its final adverse determination. BCBSM provided its response on July 31, 2015.

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 described in BCBSM's *Blue Cross Premier Silver Benefits Certificate*<sup>1</sup> (the certificate).

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<sup>1</sup> BCBSM form no. 603F; federal approval 11/14, state approval 02/15; effective 2015.

The Petitioner has Charcot-Marie-Tooth disease, a condition that affects the peripheral nerves in his leg. His physician, believing that braces would help him function, prescribed bilateral custom-made ankle-foot orthoses. The Petitioner obtained the orthoses from Ortho Rehab Designs, an out-of-network provider, on February 12, 2015. The charge was \$13,000.00.

BCBSM determined that its “approved amount” for the braces was \$2,738.37. It applied \$1,400.00 of that amount to the Petitioner’s in-network deductible, applied \$669.19 for coinsurance, and then paid the Petitioner the balance of \$669.18.

The Petitioner, believing that BCBSM should pay more for the orthoses, appealed BCBSM’s decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated June 23, 2015, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

In his external review request, the Petitioner questioned BCBSM’s methodology for determining its “approved amount.” That is an issue that cannot be addressed in a review under the Patient’s Right to Independent Review Act. In this review the Director can only determine if BCBSM processed the claim for the orthoses under the terms and conditions of the Petitioner’s coverage.

### **III. ISSUE**

Did BCBSM correctly process the claim for the Petitioner’s orthoses?

### **IV. ANALYSIS**

There is no dispute that the orthoses were medically necessary; BCBSM acknowledged that in its final adverse determination. There is also no dispute that the orthoses were a covered benefit. The issue in this case arises from the fact that the orthoses were obtained from an out-of-network, nonparticipating provider.

According to the certificate (p. 10), the Petitioner has “PPO coverage” and there are advantages when he uses in-network providers:

PPO coverage uses a “Preferred Provider Organization” provider network. What you must pay depends on the 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 certificate (p. 10) further explains what happens when an out-of-network provider is used:

Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, copayment and coinsurance as payment-in-full for covered services. Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount.

Ortho Rehab Designs is both out-of-network and nonparticipating.

The certificate (p. 10) also says that BCBSM pays its “approved amount” for covered services. “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 . . . are subtracted from the approved amount before we make our payment.

In this case, BCBSM determined that its maximum payment level for the orthoses was \$2,738.37. Because that amount was lower than the provider’s billed charge of \$13,000.00, it became BCBSM’s approved amount. BCBSM pays its approved amount to both in-network and out-of-network providers. If Ortho Rehab Designs had been an in-network or participating provider, it would have accepted the approved amount as payment in full.

The Petitioner thought BCBSM should pay Ortho Rehab Designs more. On the external review request form the Petitioner wrote:

I have a condition, CMT [*Charcot-Marie-Tooth disease*], which requires leg braces to function. My physician prescribed . . . Orthotics to correct the many problems with my feet and legs, as previous braces were ineffective.

I first checked with my insurance provider, BCBSM, and was told that yes, my plan covers this, so I went ahead and had Ortho Rehab Designs make the braces for me.

The amount that BCBSM approved, \$2,738.37, was substantially less than the billed amount, \$13,000, with no explanation as to the difference. I could not possibly get orthotic braces that cover my needs at that price.

I am seeking coverage for the amount of \$13,000.00.

In a July 10, 2015, letter sent with the external review request the Petitioner explained his understanding of how BCBSM would calculate its payment:

. . . I and my provider checked my coverage benefits and we were told that benefits are determined by Medical Necessity and payment is determined by Usual and Customary rates.

The usual and customary rate for the . . . custom leg braces I received is

\$13,000.00 for a pair. Ortho Rehab Designs always bills this amount for making this type of leg brace, and it is their Customary Charge per the attached paperwork. They have also provided me with Explanation of Benefits from other insurance companies showing that the billed amount is their usual and customary rates, and that these insurance companies allow the full charge when determining payment.

However, BCBSM pays its approved amount, not usual and customary charges, and there is nothing in the certificate that requires BCBSM to pay a nonparticipating provider more than its approved amount. Moreover, as the certificate notes, a nonparticipating provider like Ortho Rehab Designs may bill the Petitioner for any difference between its charge and BCBSM's approved amount.

The certificate (p. 12) says that the Petitioner is required to pay a \$1,400.00 individual deductible each calendar year for covered services from in-network providers. BCBSM treated the claim as an in-network service and applied \$1,400.00 of its approved amount to that deductible.<sup>2</sup> The certificate (p. 14) also says prosthetics and orthotics are subject to a 50% coinsurance after the in-network deductible has been met. BCBSM explained this in its final adverse determination:

In this instance, the BCBSM approved amount for your leg braces is \$2,738.37. Prior to the date of service at issue, you had not accumulated any payments toward your contractual deductible requirement. . . . On page 12 of Section 2: What You Must Pay, your certificate states that your annual deductible for in network services is \$1,400.00. Page 13 of Section 2 further explains that when a PPO provider refers you out of network to receive services, out-of-network deductible requirements are not imposed; rather, charges for those services are subject to your in-network deductible. In this case, a PPO provider . . . provided a referral, and as a result, the first \$1,400.00 of Ortho Rehab Design Prosthetics' charge was applied to satisfy your contractual in-network deductible requirement.

Of the remaining balance, you are responsible for \$669.19 in charges to your in-network coinsurance. . . . Page 14 of Section 2 explains that charges for prosthetics and orthotics are payable subject to your contractual coinsurance requirement. Like your deductible, your coinsurance is processed as in-network if the out-of-network services are supported by a referral from a PPO provider. It is further explained on page 14 that, under your contract, prosthetics and orthotics are subject to 50 percent in-network coinsurance after your in-network deductible has been paid. In this case, after your in-network deductible had been satisfied, \$669.19 (representing 50 percent of the provider's remaining charge of \$1,338.37)

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<sup>2</sup> If the claim had been treated as an out-of-network service it would have been subject to a \$2,800.00 out-of-network deductible and 70% coinsurance.

was applied to your in-network coinsurance, and the balance of \$669.18 was paid by BCBSM.

After considering the foregoing, the Director concludes that BCBSM correctly processed the claim for the Petitioner's orthoses.

**V. ORDER**

The Director upholds BCBSM's final adverse determination of June 23, 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.

Patrick M. McPharlin  
Director

For the Director:

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

Randall S. Gregg  
Special Deputy Director