

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. 149626-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 5th day of October 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) thought that Blue Cross Blue Shield of Michigan (BCBSM) failed to apply the out-of-pocket maximum for her coverage when it processed claims in 2014.

On August 31, 2015, ██████████, the Petitioner's mother and authorized representative, filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's claims processing decisions the 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 September 8, 2015.

The Petitioner receives health care benefits through an individual plan underwritten by BCBSM. The Director 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 initial response on September 17, 2015; and, additional information was provided on September 22, 2015.

This case presents an issue of contractual interpretation. 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 the BCBSM *Keep Fit and Member Edge Individual Market Certificate*¹ (the certificate). The certificate is amended by *Rider IOC \$2,500/\$5,000-I, \$6,000/\$12,000-O, \$6,000/\$12,000 OOPM Inpatient and Outpatient Cost-Sharing Requirements* (the rider). This coverage was in effect on the dates of service at issue in this review.

From May 20 to December 17, 2014, the Petitioner received medical services from various panel providers. After BCBSM processed the claims for those services, the Petitioner, believing that her out-of-pocket maximum for panel services had been exceeded, appealed BCBSM's decisions through its internal grievance process.

At the conclusion of that process, BCBSM issued a final adverse determination dated July 1, 2015, affirming its decisions with modification. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly apply cost-sharing to the out-of-pocket maximum?

IV. ANALYSIS

Petitioner's Argument

In a letter to DIFS dated August 26, 2015, included with the external review request, the Petitioner's mother explained her complaint:

The Out of Pocket Maximum was made clear to us when we purchased this health policy with Blue Cross Blue Shield of Michigan. Every document and brochure explaining the plan indicated a \$6,000 Out of Pocket Maximum. We were never notified through any channel whatsoever that this amount could or would change or that [an] amendment existed where an increase from \$6,000 was possible. . . .

1) Within the out of pocket maximum, all of the deductible and coinsurance is included as illustrated in the copy of the brochure I have enclosed.

2) On page two of the adverse letter they list a Revenue code Y2780 (other implants). Was performed as an outpatient procedure on July 17, 2014. [The Petitioner] didn't have anything implanted in her. We have no idea what this is.

When my child was rushed into emergency immediately after the MRI, all the exams, medical attention, hospital stay and labs were requested by the

¹ BCBSM form no. 351D, approved 05/14.

neurological team at the [REDACTED]. None of it was done out of haste but as necessary exams due to the nature of the discovery.

The out of pocket maximum is all that kept appearing on the Explanation of Benefit.

Not once during any one of the numerous phone calls to BCBSM regarding this issue during this very delicate time in [the Petitioner's] life were we told that the Out of Pocket Maximum would increase or change.

BCBSM's Argument

After the Petitioner initiated her internal grievance, BCBSM reviewed her claims and changed its decision about three of them. In the final adverse determination, BCBSM said:

. . . After review, the outpatient hospital services performed on May 24 (\$505.00) and June 25, 2014 (\$11.00) that previously denied payment for a preexisting condition have been approved. Payment will be made to the providers soon. You have no liability for these two charges.

BCBSM also decided to reprocess the claim for hospital services on July 17, 2014, and pay the claim in full with no cost sharing for the Petitioner.

BCBSM agrees that the Petitioner's out-of-pocket maximum for panel services in 2014 was \$6,000.00 but says she did not reach the maximum that year. BCBSM further explained in the final adverse determination why it denied coverage for a laboratory test on May 20, 2014:

Procedure code 83721 (lipoprotein, direct measurement; LDL cholesterol) was performed as part of your office visit on May 20, 2014. According to the Blue Cross Blue Shield of Michigan Benefit Package Report for your group, procedure code 83721 is only payable once per calendar year. Also on May 20, 2014, procedure code 80061 (lipid panel) was performed. Both of these procedures are tests for cholesterol and are therefore duplicate procedures under the terms of your health care certificate. Because cholesterol testing is only payable once per calendar year under your certificate, procedure code 80061 was payable, but procedure code 83721 was not. This means procedure code 83721 is not a payable benefit; therefore, it is a non-covered service. Charges for non-covered services are not applied toward you deductible, and subsequently, not toward your out-of-pocket maximum. You remain liable . . . for \$22.00 for this non-covered procedure.

Director's Review

The Petitioner believes that she exceeded the out-of-pocket maximum for panel services in 2014. In order to review the Petitioner's complaint, the services she received that year are displayed in a table attached to this order. Based on that table (derived from information in the

record), the Director concludes that the Petitioner did not reach the out-of-pocket maximum in 2014.

The Petitioner is correct that there was a \$6,000.00 out-of-pocket maximum for panel services, both inpatient and outpatient, in 2014. The rider (p. 5) amended the certificate to establish the panel provider out-of-pocket maximums for both inpatient and outpatient services:

Panel Provider Inpatient Annual Out-of-Pocket Maximum

Your annual out-of-pocket maximum for panel services is the sum of the panel deductible and panel coinsurance maximum and is:

- \$6,000 for a one-person contract

* * *

Panel Provider Outpatient Annual Out-of-Pocket Maximum

Your annual out-of-pocket maximum for panel outpatient services is equal to the panel outpatient deductible and is:

- \$6,000 for a one-person contract

While it appears that there are two out-of-pocket maximums, the rider (p. 4) explains that only one \$6,000.00 maximum for inpatient and outpatient cost sharing must be met:

Out-of-Pocket Maximums

Your annual out-of-pocket maximum for inpatient and outpatient cost-sharing may be satisfied in one of three ways:

- You meet both the inpatient deductible and inpatient coinsurance maximum²
- You meet the outpatient deductible requirement,³ or
- You meet any combination of the sum of the inpatient and outpatient cost-sharing requirements to equal the out-of-pocket maximum.

The Petitioner could meet the 2014 out-of-pocket maximum by meeting the panel outpatient deductible (\$6,000.00) or by combining panel outpatient and inpatient deductibles to reach \$6,000.00.

However, not all out-of-pocket expenses count towards the out-of-pocket maximum. The certificate (p. 2.7) says:

Flat dollar copayments are not counted toward the panel provider out-of-pocket maximum.

2 The inpatient coinsurance maximum is \$3,500.00 but no coinsurance was applied for any of the panel services the Petitioner received.

3 The deductible requirement for outpatient services from panel providers is \$6,000.00 (rider, p. 2).

Thus, the \$450.00 in flat dollar copayments the Petitioner made for office visits and the emergency room cannot be applied toward to the out-of-pocket maximum. Further, the certificate (p. 2.3) says:

We will not apply charges toward your deductible that exceed our approved amount or are for non-covered services or copayments.

Consequently, the \$22.00 for the non-covered laboratory test on May 20, 2014, cannot be applied to the Petitioner's deductible for outpatient services and therefore will not be credited towards the out-of-pocket maximum.

The attached chart shows that the Petitioner only had \$5,979.47 of creditable out-of-pocket expenses and therefore did not meet the out-of-pocket maximum of \$6,000.00 for the year. Therefore, the Director concludes that BCBSM correctly applied the terms of the certificate and rider when it processed the Petitioner's claims for 2014.

V. ORDER

The Director upholds BCBSM's July 1, 2015 final adverse determination with the modifications that BCBSM decided to make: the hospital observation on May 24, 2014; the laboratory test on June 25, 2014, and the hospital services on July 17, 2014. The Director concurs with BCBSM's determination that the Petitioner did not exceed her out-of-pocket maximum for 2014.

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. See 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.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director