

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. 151111-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 25<sup>th</sup> day of December 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) was denied coverage for mental health services by her health insurer.

On December 2, 2015, she filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on December 9, 2015.

The Petitioner receives health care coverage 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 used to make its final adverse determination. BCBSM responded on December 16, 2015.

The issue in this external review can be decided by a contractual review. 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 health care benefits are defined in the *Blue Cross Metro Detroit EPO Silver Extra Benefits Certificate*<sup>1</sup> (the certificate).

On August 21 and 26, 2015, the Petitioner received mental health services from [REDACTED], DO. The charge was \$1,048.00. [REDACTED] is not in the network for the Petitioner's health plan and BCBSM denied coverage for this care.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of the process BCBSM affirmed the denial in a final adverse determination dated November 17, 2015. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's mental health services?

### IV. ANALYSIS

#### Petitioner's Argument

In a letter to BCBSM dated October 4, 2015, filed with the request for an external review, the Petitioner explained her position:

. . . On August 20, 2015 I called the mental health phone number listed on the back of my insurance card in order to find a provider that would be covered by my insurance. I was sent a list of covered providers and I made an appointment with [REDACTED], who was on the list that was sent by your staff. That same day, his office called and confirmed with your staff that my visits would be covered by my insurance. I kept an appointment on August 21<sup>st</sup>, as your staff had twice confirmed that it would be covered. I called your customer service after this appointment to triple check the coverage. Again I was assured that my care would be covered by my insurance plan. I had previously met my deductible and out of pocket expense limit. I therefore proceeded with another appointment on the 26<sup>th</sup> of August, confident that my visits would be covered.

On September 1<sup>st</sup>, 2015 I was notified by the doctor's office that my visits would not be covered. I followed up with a call to Blue Cross and was again told the visits would not, in fact, not be covered. . . .

\* \* \*

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<sup>1</sup> BCBSM form no. 830H, effective August 2015.

Therefore, I would like to file a formal grievance for the charges still outstanding regarding the visits . . . on 8/21/15 and 8/26/15. I did everything I was required to do in order to have the visits covered. I used the list your employees gave me. The coverage was double checked by me through two phone calls and also checked again by [REDACTED] office. All of these checks said that my visits were covered. That they were not lies entirely with your staff and should not be held against me. Had I been given proper information at the start, this entire incident could have been avoided. I expect that these charges will be paid in full with no cost to me, as my deductible has already been met for this year.

Respondent's Argument

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

. . . After review, I must maintain denial of payment for these services. Under your coverage, we pay for covered services only when they are performed by a provider who is in the Exclusive Provider Organization (EPO) network. Dr. Halpern is not part of the EPO network, and as such, payment cannot be approved for the non-covered charges of \$850.00.

\* \* \*

Page 10 of your certificate further states "out-of-network services are not covered except to treat accidental injuries, medical emergencies, or when the covered services are not available in the EPO network and BCBSM has preauthorized the services."

\* \* \*

While mental health services are covered under your certificate, [REDACTED] [REDACTED] is not a contracted provider in the EPO Network. Because he is not an EPO provider, and because there was no preauthorization requested for his services, we cannot approve payment. Incidentally, the claim for the August 26, 2015, date of service processed at the in-network benefit level. However, it appears this claim processed at the in-network level in-error. The service does not meet the required criteria for in-network processing. A recall will not be initiated at this time. However, the claim may be subject to an audit in the future.

While I regret you may have received misleading information from a BCBSM customer representative, we must process claims according to the terms and conditions of your coverage.

Director's Review

The Petitioner's health plan provides services through a limited network. The certificate (p. 9) explains how the plan works:

You have EPO coverage under this certificate. EPO coverage uses an Exclusive Provider Organization (EPO) provider network. . . . BCBSM pays for covered services rendered only when they are covered under this certificate and performed by a provider who is in the EPO network. You will be required to pay the deductible, copayment and coinsurances listed in this certificate for their services.

\* \* \*

BCBSM pays for covered services to treat a medical emergencies or accidental injuries performed by providers not in the EPO network. Your cost sharing requirements in this certificate will apply.

**Out-of-network services are not covered**

When covered services are not available in the EPO network, as determined by BCBSM, a preauthorization will be required from BCBSM. Services preauthorized by BCBSM for this purpose will be covered, and the in-network cost sharing requirements listed in this certificate will apply.

Under the Petitioner's plan, services (other than for emergencies or accidental injuries) are covered only if rendered by a network provider or authorized in advance by BCBSM. There is no dispute that [REDACTED] is not in the exclusive provider network for the plan or that BCBSM did not authorize coverage for his services. Therefore, the Director concludes that BCBSM correctly denied coverage for [REDACTED] treatment.

The Petitioner says that BCBSM told her that care provided by [REDACTED] would be covered. She also says that this information was confirmed when her doctor's office contacted BCBSM by phone. BCBSM does not refute her contentions.

However, in a review under the Patient's Right to Independent Review Act (PRIRA), the Director does not have the authority to amend the terms of an insurance policy even if the Petitioner was given inaccurate information regarding her benefits by BCBSM's representative. Under PRIRA, the Director can only determine if BCBSM's final adverse determination is consistent with the terms of the certificate and state law. The Petitioner may have other remedies outside of PRIRA for any complaints that are not dealt with in this Order.

The Director finds that BCBSM's denial of the care provided by [REDACTED] is consistent the terms and conditions of the certificate.

**V. ORDER**

The Director upholds BCBSM's November 17, 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