

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. 152761-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 8th day of April 2016
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 18, 2016, ██████████ (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.* The Director accepted the request on March 25, 2016.

The Petitioner received health care benefits through a group plan that is underwritten by Blue Cross Blue Shield (BCBSM). The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM responded on March 29, 2016.

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 health care benefits are described in BCBSM's *Community Blue Group Benefits Certificate SG1* (the certificate).

On September 17, 2015, the Petitioner had an OVA1 test, a blood test used to help

evaluate the risk of ovarian cancer. The test was performed by Aspira Labs (Aspira). Aspira does not participate with BCBSM or a local Blue Cross Shield plan in Texas, where it is located.

Aspira charged \$1,495.00 for the test. BCBSM's approved amount for the test was \$300.00. BCBSM first applied \$233.49 to the Petitioner's deductible for in-network services, then applied 20% coinsurance of \$13.30, and then paid the provider \$53.21. Accordingly, the Petitioner was responsible out of pocket for a total of \$246.79 after BCBSM processed the claim. However, the Petitioner was billed by Aspira for \$450.00.

The Petitioner appealed the amount BCBSM paid for the test through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated January 19, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is BCBSM required to pay an additional amount for the laboratory test?

IV. ANALYSIS

Petitioner's Position

In her request for an external review, the Petitioner wrote:

On 9-17-2015 I had an OVA-1 test and was told by my provider the cost would be approximately \$250. This was confirmed by my EOB [*explanation of benefit payments*]. . . . The EOB said I would [be responsible for] \$246.79. Much to my surprise Aspira Labs billed me for \$450.00. I was told they do not participate with BCBS PPO. I feel BCBS should've known this and given me an accurate quote on my EOB. Therefore, I am requesting that BCBS reimburse me for the difference between what my EOB quoted and what I was charged by Aspira. \$450 - \$246.79 = \$203.21.

BCBSM's Position

In its January 19, 2016, final adverse determination BCBSM's representative told the Petitioner:

. . . After careful review, I confirmed the claim processed correctly. We reimbursed Aspira at the maximum payment level (approved amount) available for the reported service. Because Aspira is nonparticipating with BCBSM, you can be billed for the difference between our approved amount and the billed charges.

At the time of service, you were covered under the *Community Blue Group Benefits Certificate SG*. Page 18, (*Section 3 What BCBSM Pays For*), explains that we pay our approved amount for the services you receive that are covered in this certificate. Page 140, (*Section 7: Definitions*), explains that the approved amount is the maximum payment level for a covered service. Page 35 (*Section 3: What BCBSM Pays For*), explains that we pay for laboratory and pathology tests needed to diagnose a disease, illness, pregnancy or injury.

Page 8, (*Section 2: What You Must Pay*), explains that you have the least amount of out-of-pocket expenses when you receive services from a participating PPO provider. If the provider is participating, our approved amount is accepted as payment in full for covered services. However, if you receive services from an out-of-network nonparticipating provider, who has not signed a participating agreement with BCBSM, you may be responsible for all charges that exceed our approved amount.

* * *

Page 9, Section 2: What You Must pay, explains that you are required to pay an annual deductible of \$250.00 for one member and \$500 for the family for covered services. If the one member deductible has been met, but not the family deductible we pay for covered services for that member that has met the deductible. Page 12 explains that you are required to pay a 20 percent coinsurance for most covered services after you have met your deductible. Rider CB-\$250-2015 SG- Community Blue Cost-Sharing Requirements explains the coinsurance you are required to pay each calendar year is limited to \$500 for one member and \$1,000 for the family.

I confirmed the following regarding the claims in dispute:

- The total charge for procedure code 81503 is \$1,495.00. The BCBSM approved amount for the covered service is \$300.00.
- On the date of service, you had not yet met your annual deductible requirement of \$250.00. As a result, BCBSM appropriately applied \$233.49 to you deductible to meet your requirement. Also, BCBSM appropriately applied a 20 percent coinsurance to the covered service totaling \$13.30.
- BCBSM appropriately reimbursed Aspira Labs a total of \$53.21. No other reimbursement from BCBSM can be approved.
- Because Aspira Labs, is nonparticipating with BCBSM, they do not have an agreement to accept our approved amount as payment in full, you can be billed for the charges above our approved amount.

In your appeal letter and during your managerial-level conference, you stated that you should not be liable for the difference between our approved amounts and the

billed charges because you were under the impression that your services was provided by a BCBSM participating PPO provider. While we understand your position, we are bound by the provisions of your coverage. As explained, reimbursement is limited to the BCBSM approved amount for covered services. Because Aspira is nonparticipating with BCBSM, I am unable to intervene on your behalf regarding your balance. The balance is a matter between you and the health care provider.

Director's Review

The Petitioner wants BCBSM to pay more for the laboratory test because she says she was told by her "provider" that her out-of-pocket cost would only be \$250.00. It is not clear in this record that BCBSM was even aware that the test would be performed by a nonparticipating provider. In any event, the Director concludes that the claim for the laboratory test was correctly processed.

The certificate (p. 35) covers diagnostic laboratory services; those services are subject to both the deductible and coinsurance (p. 9). The certificate (p. 8) also says:

You have PPO coverage under this certificate. 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.

* * *

Important: 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.

Aspira is not in the PPO network for the Petitioner's plan, nor does it participate with BCBSM or a Blue Cross Blue Shield plan in Texas where it is located. The certificate (p. 117) states: "If the out-of-network provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial."

As a nonparticipating provider, Aspira is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for \$1,441.79, the difference between its billed charge (\$1,495.00) and BCBSM's payment (\$53.21). In this case, Aspira apparently gave the Petitioner a courtesy discount of \$991.79 and only billed her for \$450.00.

The Director concludes and finds that BCBSM correctly processed the claim for the OVA1 laboratory test according to the terms and conditions of the certificate.

V. ORDER

The Director upholds BCBSM's final adverse determination of January 19, 2016.

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:



Sarah Wohlford
Special Deputy Director