

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

[REDACTED]

Petitioner,

v

File No. 148760-001

Blue Care Network of Michigan,

Respondent.

Issued and entered
this 3rd day of August 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 10, 2015, [REDACTED] (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 (PRIRA), MCL 550.1901 et seq. The Director reviewed the request and accepted it on July 17, 2015.

The Petitioner received health care benefits through Blue Care Network of Michigan (BCN), a health maintenance organization. The Director notified BCN of the external review request and asked for the information it used to make its final adverse determination. The Director received BCN's response on July 22, 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.

II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in a certificate of coverage for a high deductible health plan for individuals (the certificate). The certificate is amended by the *Medical Cost Sharing Rider Bronze High Deductible Health Plan* (the rider).

On January 17, 2015, the Petitioner went to the emergency department of [REDACTED] Hospital because of an injury to her right arm. While in the emergency department the Petitioner received services from [REDACTED] Emergency Physicians [REDACTED], an out-of-network provider. The emergency department report said:

Patient seen and examined. Patient is given Percocet and x-rays obtained. X-rays show a comminuted slightly impacted proximal humerus fracture, but with good physiologic alignment and in view of this, the patient is placed in a shoulder immobilizer. . . . She is placed in a shoulder immobilizer, given copies of her x-rays, given instructions and discharged.

[REDACTED] charged \$1,173.00 for its services. BCN's approved amount for those services was \$967.83 and it applied that amount to the Petitioner's annual deductible. Because [REDACTED] is an out-of-network provider and not bound to accept BCN's approved amount as payment in full, it billed the Petitioner for the balance of its bill over BCN's approved amount or \$205.17 in addition to the deductible. This meant the Petitioner was responsible out of pocket for NMEP's entire charge of \$1,173.00.

The Petitioner, unhappy with the amount of [REDACTED] charges as well as the quality of care she received, appealed through BCN's internal grievance process. BCN's grievance panel issued a final adverse determination dated June 18, 2015, affirming its initial benefit determination.

The Petitioner now seeks a review of that final adverse determination from the Director. Because quality of care issues cannot be addressed in a review under the PRIRA, this review will be limited to whether BCN properly processed NMEP's claims under the terms of the Petitioner's coverage.

III. ISSUE

Did BCN correctly process the claim for the Petitioner's emergency department services from [REDACTED]

IV. ANALYSIS

Petitioner's Argument

In a letter dated July 9, 2015, submitted for this external review, the Petitioner wrote:

[BCN] sets my premium, determines what I pay out of pocket without consideration if I receive quality care. I am asking for a lowering of the outrageous amount billed and/or elimination of the bill for substandard service. I

only had about 4 minutes with the doctor who did not examine me, and a nurse squeezing my broken arm; with no room on form to list other items: like being put in a room, left alone without any ability to contact staff - if I had passed out I would have fallen to the floor - not even near an emergency buzzer to call for help.

My daughter was in the emergency room in Dec 2014, and March 2015 (for auto accident) and in each instance the emergency room physician only billed about \$500 for their services, not \$977.

In a letter to BCN dated May 18, 2015, appealing the emergency room physician's charges, the Petitioner wrote:

Please note I requested abstract from Emergency room department since their billing department could not tell me what I was being billed for. The doctor's report is not even relevant to the treatment of my broken right arm. He wrote about the left arm in his report. Only the x-ray report discusses right arm. He gave me no exam. He did not examine my injury. He did nothing except sit 4 feet away from me for about 3 minutes. His billing department refuses to accept the amount that BCN approved, but continually bill me for the gross amount of \$977.00.

. . . I have no say in what BCN says I must pay, even if I did not get the treatment. This is unethical. There is an unwritten agreement with BCN and the provider that allows outrageous payments for 'fracture care' that was not disclosed to me, yet I am expected to pay whatever is written on the bill. BCN pays none of these charges, but tells the provider that it is OK to charge me even though there was no reasonable service or care. This is wrong. . . .

I have paid all of my other bills for care – as long as I can verify that the care was received. This doctor did nothing to care for my injury.

The Petitioner wants BCN to waive the deductible for the services she received from NMEP.

Respondent's Argument

In its final adverse determination, BCN's representative wrote:

. . . Our grievance panel . . . reviewed the information you submitted and presented along with medical records and your benefits for your request for the [*emergency department*] charges to be waived, and upheld the previous denial. We based our decision on the fact that the deductible amounts were applied correctly. The claims paid according to the Federal Government and American Medical Association guidelines in billing.

In an earlier letter to the Petitioner dated April 17, 2015, BCN explained its position:

We have completed our review of your complaint regarding the out of pocket (OOP) applied to the above referenced services.

In your correspondence, you advised that you do not feel you should have to pay for care that you did not receive, such as the surgical procedures billed on [January 17, 2015].

During our conversation on 04/14/2015, I advised that the classification of the codes as surgical is not determined by the physician who is billing the care nor Blue Care Network (BCN); it is standard practice for fracture care as part of a global package. I confirmed that the information regarding this practice is available online and I would send you a copy of the information I obtained. I also advised that had the services been considered diagnostic or therapeutic, the benefit applied would have not been different.

After a thorough evaluation of your request, including your benefits and plan requirements, it was determined that the deductible was applied correctly for the services billed and your OOP cannot be waived.

Director's Review

The Petitioner's complaint about the quality of care she received cannot be addressed in this external review because the Director has no authority over medical providers. The Director can only review the terms of the Petitioner's coverage and determine if BCN correctly processed the claims from [REDACTED]

The *Medical Cost Sharing Rider* amended the certificate to establish an annual deductible of \$5,950.00 per individual and \$11,900.00 per family; the deductible renews each calendar year. The rider says the deductible applies to all covered services except preventive care. Thus, the emergency room services were subject to the deductible.

Regarding payment for emergency care, the certificate (subsection 8.6, p. 35) says:

We will pay the BCN Approved Amount. Our Approved Amount is the greater of the median in-network rate, the usual, customary and reasonable rate, or the Medicare rate. You are responsible for any Cost Sharing required under your Rider.

BCN determined that its approved amount for the services provided by [REDACTED] was \$967.83 and it applied that amount to the Petitioner's unmet annual deductible. [REDACTED] is not a participating (network) provider, i.e., it has not contracted with BCN to provide services under the Petitioner's plan, and therefore may seek payment from the Petitioner for any part of its charge that exceeds BCN's approved amount, in this case \$205.17.

Based on the foregoing, the Director concludes that BCN processed the [REDACTED] claims according to the terms and conditions of the certificate and rider and the Petitioner is responsible for the deductible applied to [REDACTED] charge as well as the difference between the charge and the deductible.

V. ORDER

The Director upholds BCN's June 18, 2015 final adverse determination.

This is a final decision of an administrative agency. Any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the Michigan county where the covered person resides or 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:



Randall S. Gregg
Special Deputy Director