

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 102213-001

v

Blue Cross Blue Shield of Michigan
Respondent

/

**Issued and entered
this 15th day of June 2009
by Ken Ross
Commissioner**

ORDER

I
PROCEDURAL BACKGROUND

On December 30, 2008, XXXXX, on behalf of her husband XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on January 8, 2009.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 19, 2009. Additional information was submitted by BCBSM June 2, 2009.

The Petitioner is enrolled for health coverage through XXXXX Corporation, an underwritten group. The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). Rider *CBD \$500.00-P* (*CB-CM Community Blue Deductible Requirement for Panel Services*) and Rider *CB-CM-P \$1,500* (*Community Blue Co-Payment for Panel Services*) also apply. The Commissioner 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

On December 19, 2007, Petitioner began to experience chest pains and went to the emergency room of XXXXX Hospital. XXXXX determined that it did not have the resources to properly treat Petitioner's condition. He was immediately airlifted to the XXXXX where it was discovered that Petitioner had a dissected aortic artery. Emergency surgery was performed. Petitioner was discharged from XXXXX on January 14, 2008.

BCBSM charged various deductibles and copayments which Petitioner believes were improper. The Petitioner appealed BCBSM's decision. BCBSM held a managerial-level conference on October 23, 2008, and issued a final adverse determination dated October 30, 2008.

On June 2, 2009, while this appeal was pending, BCBSM informed the Commissioner that it had agreed to waive its \$500.00 charge for the emergency services because of the difficulty in allocating the emergency services between XXXXX and XXXXX. BCBSM indicated that it would send the Petitioner a check for that amount.

III ISSUE

The issue to be resolved is whether the copayments assessed by BCBSM should remain the responsibility of Petitioner.

IV ANALYSIS

The Petitioner believes that "the hospital, doctors and tests . . . should be 100% covered as a life threatening medical emergency." Petitioner also argues that, because his hospitalization occurred in both 2007 and 2008, the copayment maximum should carry forward as well.

BCBSM says that, in connection with Petitioner's emergency care, it assessed a \$500 deductible which met the deductible requirements for both 2007 and 2008. In addition, it charged

copayments totaling \$1,616.29 for those years – \$1,500.00 for 2007 and \$116.29 for 2008. Because of confusion about the dates and places of the emergency services, BCBSM agreed to waive and refund the \$500 deductible. BCBSM says that its certificates do not include provisions for waiving copayments for emergency treatment.

While there is no question that the care Petitioner received was medically necessary, the coverage for that care must be determined by the terms of the certificates. Because there are no provisions in the certificate of riders waiving copayments for emergency care, the Commissioner finds that BCBSM's copayment assessments are appropriate.

V
ORDER

BCBSM is not required to waive copayments for the Petitioner's medical care received between December 19, 2007 and January 14, 2008.

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 county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2). A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.