

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. 152491-001

Blue Cross Blue Shield of Michigan

Respondent

Issued and entered
this 24th day of March 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 2, 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.* On March 9, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Simply Blue Group Benefits Certificate SG*. Cost sharing requirements are found in *Rider SB \$1,500-2015 SG*.

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 response on March 17, 2016.

This case can be resolved by applying the terms of the *Simply Blue* certificate. A medical opinion from an independent review organization is not required. See MCL 550.1911(7).

II. FACTUAL BACKGROUND

On December 9, 2015, the Petitioner had a physician's office visit to discuss her ADHD medication. The claim (#26153452948700) was processed through Providence Hospital Family Practice, a BCBSM participating provider. The provider's charge was \$169.00. BCBSM's

approved amount was \$91.58. BCBSM allocated the entire \$91.58 to the Petitioner's in-network deductible which required the Petitioner to pay that amount to the provider.

The Petitioner, questioning BCBSM's decision to apply \$91.58 to her deductible, appealed through BCBSM's internal grievance process. At the conclusion of that process, on January 20, 2016, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Did BCBSM correctly process the claim for the Petitioner's December 9, 2015, office visit?

IV. ANALYSIS

BCBSM's Argument

In the final adverse determination issued to the Petitioner, BCBSM's representative wrote:

After review, I confirmed our payment determination is correct because your policy imposes a deductible requirement for mental health services (psychiatric care). As a result, you remain liable for \$91.58.

* * *

You are covered under the *Simply Blue Group Benefits Certificate SG (Certificate)*. According to Page 14 of the *Certificate*:

Mental Health Services and Substance Abuse Treatment

Mental health services and substance abuse treatment are subject to the same annual deductible, coinsurance and copayment requirements and maximums that apply to all other in-network and out-of-network services.

Also, according to Page 56 of the *Certificate*:

Locations: We pay for mental health services in an inpatient or outpatient hospital, an approved inpatient facility, a participating residential psychiatric treatment facility, in a physician's, fully licensed psychologist's or CLMSW's office and an outpatient facility....

* * *

As explained on Page 1 of this letter and above, mental health services are payable in a physician's office and are subject to the same annual deductible, coinsurance and copayment requirements and maximums. Specifically, as explained in the *Benefit Package Report* (BCBSM's online reference tool for procedure code specific benefit information) for your group; procedure code 99213 (office visit) is subject to general deductible when the primary diagnosis is for psychological disorders. As a result, you remain liable for the in-network deductible requirement of \$91.58 to Providence Hospital Family Practice.

Petitioner's Argument

In her external review request, the Petitioner wrote:

PPACA [Patient Protection and Affordable Care Act] requires that mental health be covered equal to other medical services. Per DOL [Department of Labor] copays and deductibles may not be more stringent. BCBSM is not covering my claim on the grounds that it is mental health...even though the service is not provided by a mental health provider....

The Petitioner believes that she should only have to pay a \$20.00 copayment for the office visit. This is the same amount she paid for an office visit on the same day with a different doctor to discuss her blood pressure medication.

Director's Review

The Petitioner has ADHD and had an office visit with her physician to discuss her ADHD medication. When a claim was submitted for this office visit, BCBSM provided coverage but assessed the Petitioner a deductible charge of \$91.58 rather than an office visit copayment (\$20.00 or \$40.00 depending on whether the doctor was the Petitioner's primary care physician or a specialist – see page 12 of the *Simply Blue* certificate).

BCBSM justified its claims processing by asserting that a document called a *Benefit Package Report* (BPR) provides that office visits are “subject to general deductible when the primary diagnosis is for psychological disorders.” The BPR is not a part of the *Simply Blue* certificate. It is an internal BCBSM document apparently used by BCBSM employees as an aid in processing claims. Both the Petitioner and BCBSM submitted a copy of the BPR for the Petitioner's benefit plan and its coverage for office visits with a procedure code of 99213.

The Petitioner's actual coverage is found in BCBSM's *Simply Blue* certificate. As BCBSM acknowledges in its final adverse determination, the *Simply Blue* certificate provides:

Mental health services and substance abuse treatment are subject to the same annual deductible, coinsurance and copayment requirements and maximums that apply to all other in-network and out-of-network services.

This provision, being a part of the actual contract between BCBSM and the Petitioner's employer, governs coverage in this case. The BPR provision relied upon by BCBSM may not be cited to limit the Petitioner's coverage specified in the *Simply Blue* certificate.

By treating an office visit related to mental health care differently from other office visits (which only require a \$20.00 or \$40.00 copayment) BCBSM has produced a claim decision which is inconsistent with the *Simply Blue* certificate of coverage.

This kind of discrimination is also prohibited under federal law. It is prohibited in large group plans by the federal Mental Health Parity and Addiction Equity Act. The Patient Protection and Affordable Care Act extends this prohibition to non-grandfathered small groups through its essential health benefits provisions.

The Director finds that BCBSM incorrectly processed the claim for the Petitioner's office visit on December 9, 2015.

V. ORDER

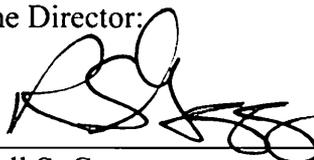
The Director reverses BCBSM's final adverse determination of January 20, 2016. BCBSM shall immediately reprocess claim #26153452948700 (office visit, procedure code 99213) to assess a \$20.00 or \$40.00 copayment and no deductible. BCBSM shall, within seven days of providing coverage, submit to the Director proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free at 877-999-6442.

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. 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