

**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. 151328-001

Blue Cross Blue Shield of Michigan,

Respondent.

---

Issued and entered  
this 15<sup>th</sup> day of January 2016  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) was denied coverage for air and ground ambulance transportation by his health care insurer, Blue Cross Blue Shield of Michigan (BCBSM).

On December 15, 2015, the Petitioner 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.* The Director accepted the case for review on December 22, 2015.

The Petitioner receives health care benefits through a group plan that is underwritten by 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 provided its response on December 29, 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 health care benefits are defined in BCBSM's *Simply Blue Group Benefits Certificate LG* (the certificate).<sup>1</sup>

The Petitioner, a resident of [REDACTED], was traveling in [REDACTED] when he became ill. He was diagnosed with acute pancreatitis among other conditions. He was treated at the [REDACTED] Clinic and then transported on March 27, 2015, by both ground ambulance<sup>2</sup> and fixed wing air ambulance to a hospital in [REDACTED], for further care.

The ambulance provider, known as [REDACTED], submitted claims to BCBSM for \$248,150.00 (air ambulance) and \$70,100.00 (ground ambulance). BCBSM denied coverage for this service saying it was not medically necessary.

The Petitioner appealed BCBSM's denial through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated October 16, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

## III. ISSUE

Did BCBSM correctly deny the claims for the Petitioner's ambulance transport?

## IV. ANALYSIS

### Petitioner's Position

In the external review request, the Petitioner wrote:

Doctors at [REDACTED] Clinic stated I needed to stay approximately 1 to 2 more weeks [*in the hospital*]. My wife was ill and does treatment in [REDACTED]. My children needed to get back to [REDACTED] for their jobs. It was costing my family approximately \$700 per day to stay in [REDACTED].

The Petitioner paid [REDACTED] an "initial retainer" of \$15,700.00 (plus \$527.00 credit card handling fees). He would like to be reimbursed for that amount.

### BCBSM's Position

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

---

<sup>1</sup> BCBSM form no. 778E, effective 2015.

<sup>2</sup> The ground ambulance transport was apparently for transport to the aircraft from the [REDACTED] Clinic and from the aircraft to the hospital in [REDACTED].

After review, it was determined that payment could not be approved because criteria for coverage was not met.

\* \* \*

A board-certified M.D. in Family Medicine reviewed your claims, your appeal, and your health care plan benefits for [BCBSM]. Our medical consultant determined:

We have reviewed your ambulance transport that took place on March 27, 2015. We initially received a prior authorization request for this transfer on April 1, 2015 and this request was not approved. You were transported from the [REDACTED] Clinic in [REDACTED] to [REDACTED] after you were hospitalized because you developed acute pancreatitis while you were traveling. Your treating physician at the [REDACTED] Clinic indicated that you were transferred to be closer to home and your family support system. There was no indication that you were not able to receive treatment of your condition while you were in the [REDACTED] Clinic. According to the limited medical record provided, your condition was improving. Per the BCBSM Medical Policy titled, "Ambulance Services," ambulance transport is considered established when the transport is determined to be medically necessary and you are transported to the nearest facility that is able to provide the necessary treatment. We have not received any documentation that the [REDACTED] Clinic was not able to provide the necessary treatment for your condition. Therefore, we are not able to approve your ground and subsequent air ambulance transport to [REDACTED]

Because the criteria for coverage was not met, payment cannot be approved for your air and ground ambulance services.

#### Director's Review

Ambulance transport, both air and ground, is a benefit under the Petitioner's plan. The benefit is described in the certificate (pp. 19-20):

#### **Ambulance Services**

\* \* \*

#### **We pay for:**

Ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition.

In any case the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.
- The fee must be only for the transportation of the patient, and does not include additional services that may be provided by physicians or other professionals and billed as ambulance services.
- The service must be to transport the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility, medical clinic or the patient's home.

Note: When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and that is part of a licensed ambulance operation.

\* \* \*

#### Air Ambulance

When transportation by air ambulance is required, the following conditions must be met:

- The use of an air ambulance is medically necessary and ordered by the attending physician

Under the certificate, ambulance service is a benefit to transport a patient to "the nearest medical facility capable of treating the patient's condition." There is nothing in the record to show that the Petitioner could not have continued to receive appropriate treatment at the [REDACTED] Clinic or that the hospital in [REDACTED] was the nearest facility capable of treating him.

The notes from BCBSM's grievance conference indicate the Petitioner's concern about the expenses his family was incurring by staying in a hotel while he was in the hospital in [REDACTED]. The Petitioner also explained on the external review request form that his wife was ill and was being treated in [REDACTED]. It is understandable that the Petitioner would want to be treated close to his home and support system in [REDACTED] and save his family expenses, but those reasons alone do not meet the requirements of the certificate.

The Petitioner's physician at the [REDACTED] Clinic even said that the transport was arranged to allow the Petitioner "to receive medical care with his established physician at a facility close to his home and support system." While the physician's May 4, 2015, "Letter to Medical Necessity" explained why the Petitioner, given his medical status, had to be transported in a medically-configured aircraft if he was to travel to Tulsa at that time, it did not justify any medical need for moving the Petitioner to [REDACTED].

The Director concludes that BCBSM's denial of coverage for the Petitioner's ambulance services was consistent with the terms and conditions of the certificate.

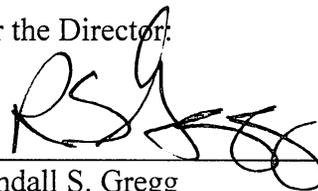
**V. ORDER**

The Director upholds BCBSM's final adverse determination of October 16, 2015.

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 'RS Gregg', is written over a horizontal line.

Randall S. Gregg  
Special Deputy Director