

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

In the matter of:

██████████
Petitioner

v
Blue Cross Blue Shield of Michigan
Respondent

File No. 146582-001

Issued and entered
this 25th day of March 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 27, 2015, ██████████ (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, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner has health care coverage under a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Community Blue Group Benefits Certificate SG*. The Director notified BCBSM of the external review request and asked for the information used to make its adverse determination. BCBSM submitted the material on March 17, 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

On July 1, 2014, the Petitioner underwent abdominal surgery at the ██████████ Surgery Center, an ambulatory surgical facility in ██████████. The surgery was performed by ██████████. Neither the ██████████ Center nor ██████████ participates with BCBSM or a ██████████ Blue Cross Blue Shield insurer. ██████████ charged \$33,000.00 for the surgery. ██████████ Center charged \$41,578.00.

In its initial claims processing, BCBSM approved \$795.60 for [REDACTED] surgery and denied coverage for the surgical center's charges. Later, BCBSM agreed to pay an additional \$1,373.40 for [REDACTED]' surgery bringing BCBSM's total payment to \$2,169.00. The Petitioner appealed the claims decisions through BCBSM's internal grievance process. BCBSM issued its final adverse determination on January 2, 2015. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claims related to the Petitioner's July 1, 2014 surgery?

IV. ANALYSIS

BCBSM's Argument

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

A board-certified M.D. in General Surgery reviewed your claim, your appeal, the medical records provided and your health care plan benefits for Blue Cross Blue Shield of Michigan (BCBSM). Based on that review, payment was approved for procedure code 49999 (unlisted procedure, abdomen, peritoneum and omentum) and procedure code 49320 (laparoscopy, abdomen, peritoneum and omentum). Additional payment of \$1,016.20 will be issued shortly. In regard to procedure codes 49505 (repair initial inguinal hernia) and procedure code 49870 (repair epigastric hernia) our initial payment determination is correct. We already issued the maximum benefit available for the services. As a result, no additional payment can be made.

[W]e are maintaining our denial of payment [for the surgical center's charge] because the service provided is not a benefit when performed by a non-participating provider under your plan. As a result, you remain responsible for the charge.

You are covered under the *Community Blue Group Benefits Certificate SG*. This is a Preferred Provider Organization (PPO) plan. In the *Certificate* on page 154, it explains a nonparticipating provider is a physician and other health care professional, or hospital and other facility or program that has not signed a participation agreement with BCBSM to accept the approved amount as payment in full. As a result, nonparticipating providers can bill you for the difference between their charges and our approved amount.

In addition, on page 139 of the *Certificate*, it describes the approved amount as the lower of the billed charge or our maximum payment level for the covered

service. Any deductible and/or copayment required are subtracted from the approved amount before we make our payment.

In this case, as you acknowledged, [REDACTED] is a nonparticipating provider who required you to pre-pay for both the professional and facility services. I confirmed that there was a participating provider referral from [REDACTED]. As a result, the claims were processed in-network....

In addition, on pages 118-119 of the *Certificate*, it describes how nonparticipating providers are paid. BCBSM's coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency. However, we do not pay for services provided at nonparticipating freestanding ambulatory surgery facilities. On page 139 of the *Certificate* it describes an ambulatory surgery facility as a freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient care.

In this case, [REDACTED] Surgery Center, LLC is a nonparticipating freestanding ambulatory surgery facility. As a result, the service provided is not a benefit.

Petitioner's Argument

In her request for an external review, the Petitioner submitted the following explanation of her position:

I am seeking to receive a fair reimbursement from [BCBSM] for my abdominal surgery on 7-1-14, where [REDACTED] made 6 repairs to my abdomen.

I tried unsuccessfully for 3 years to find a surgeon in the [REDACTED] area to fix my abdomen that had been hurting since shortly after my gallbladder surgery in 2011. Most surgeons denied that I had a problem, while others wanted to make the repairs in up to 4 surgeries. Multiple surgeries was dangerous for me with my history of pulmonary embolisms. I sought out the opinion of 8 other surgeon before deciding to go with [REDACTED], who offered to make all of the repairs in one surgery.

[REDACTED] ultimately made 6 repairs in one surgery, which is a far cry from some of the local doctors who told me I didn't have anything wrong with me. One of the repairs, core muscle, is a repair made by only a handful of doctors in the U.S. (see attachment of articles about [REDACTED] specialty). I have provided more than adequate documentation as to [REDACTED] specialty, the 8 other surgeons' opinions I sought prior to going out-of-state and why I ultimately selected [REDACTED]

I kept my Internist, [REDACTED], aware of my efforts and worked with him to make decisions on surgical opinions and my final decision. As such, [BCBSM]

acknowledges [REDACTED] role in my surgery and said the claims were paid “in-network” (see page 2, paragraph 3 of [BCBSM] letter dated January 2, 2015). However, \$2,169.00 is not a typically in-network reimbursement for major surgery. If I had followed some of the local surgeons’ recommendations for multiple surgeries, [BCBSM] could have paid ~200k for me to get my abdomen fixed. As such, I don’t think it is unreasonable to expect BCBSM to cover more of my surgery costs. I am being penalized for going to someone out-of-state who [made] the repairs in one surgery versus staying local and having four surgeries, which [BCBSM] would have paid for.

[REDACTED] office claims that BCBS typically reimburses at a high rate for surgery with their other patients with BCBS insurance. The goal of my appeal is to seek a fair (> \$2,169 received) reimbursement for my surgery on July 1, 2014.

Director’s Review

1. [REDACTED] Surgery Claim

The *Community Blue* certificate (page 26) states that BCBSM pays for covered services based upon its approved amount which is defined, on page 138, as:

The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

BCBSM pays its approved amount to both participating and nonparticipating providers. BCBSM sets its approved amount. These amounts are not regulated by the Department of Insurance and Financial Services. BCBSM participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers like [REDACTED] have not agreed to accept BCBSM’s approved amount as payment in full. Consequently, nonparticipating providers may bill their patients for the difference between their charges and BCBSM’s approved amount. The *Community Blue* certificate (page 118) warns:

If the provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial because BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency.

- To receive payment for covered services provided by a nonparticipating hospital, you will need to send us a claim. Call your customer service representative...for information on filing claims.
- You will also be responsible for the difference between our approved amount and the amount charged by the nonparticipating provider.

BCBSM paid its approved amount for [REDACTED] surgery. As a nonparticipating provider, [REDACTED] may charge the Petitioner for the balance of his fee.

2. [REDACTED] *Surgical Center Claim*

BCBSM denied coverage for the charges submitted by the [REDACTED] Center because it is a nonparticipating ambulatory facility. The *Community Blue* certificate (page 119) completely excludes coverage for services received at a nonparticipating ambulatory facility.

BCBSM does not pay for services at nonparticipating:

* * *

- Freestanding ambulatory surgery facilities

While it is understandable the Petitioner is disappointed with BCBSM's payment determination, there is nothing in the certificate that requires BCBSM to pay more than its approved amount under any circumstances, nor is it required to provide any coverage for services received at a nonparticipating freestanding ambulatory surgery facility.

The Director finds that BCBSM's correctly processed the claims for the Petitioner's July 1, 2014 surgery under the terms of the *Community Blue* certificate.

V. ORDER

The Director upholds BCBSM's January 2, 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 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). 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.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director