

**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. 147637-001**

**Blue Cross Blue Shield of Michigan,**

**Respondent.**

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**Issued and entered**  
**this 21<sup>st</sup> day of May 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On April 29, 2015, ██████████, on behalf of her minor son ██████████ (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.* The Director accepted the case for review on May 6, 2015. The review concerns a claim for ambulance transport for the Petitioner in 2013.

The Petitioner receives health care benefits as a dependent through a group plan that is underwritten by Blue Cross Blue Shield of Michigan (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 May 15, 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 was injured in an automobile accident on December 30, 2013. He was transported from the accident scene to the hospital by ground ambulance. The ambulance provider, Thompsonville Ambulance, a panel provider, charged \$712.50. BCBSM's approved amount for the transport was \$661.84 and it applied that amount to the Petitioner's unmet

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<sup>1</sup> The Petitioner was born May 9, 1997. He turned 18 years old on May 9, 2015.

deductible for in-network (panel) services.<sup>2</sup>

At the time of the transport, the Petitioner's health care benefits were defined in BCBSM's *Simply Blue Group Benefits Certificate* (the certificate).<sup>3</sup> *Rider SBD-P \$4,000/\$8,000 Simply Blue Deductible Requirement For Panel Services* amended the certificate "to increase the annual deductible requirement for covered services obtained from a panel provider."

The Petitioner appealed BCBSM's payment decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 2, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly process the claim for the Petitioner's ambulance transport?

### IV. ANALYSIS

#### Petitioner's Position

In an April 20, 2015, letter submitted with the external review request, the Petitioner's mother wrote:

I'm appealing [BCBSM's] decision because I feel BCBS representatives misguided me in my decision to turn the claim over to my auto insurance for consideration. I contacted BCBS when the first EOB [*explanation of benefit payments*] was received, which was July 2014. I was directed by the BCBS representative not to pay the bill, to actually return any bills received from Thompsonville Ambulance with a copy of my EOB. I explained that my auto insurance case was being closed and if I needed to submit something that I had to get it in and she stated the following:

"The health care provider has a limited time to send us claims after the service date. We received this claim after the last day that we can review it for benefits. No amount was paid by us. And you should not be billed."

In October 2014 I received another EOB and this time BCBS applied the entire amount to my [deductible]. I called BCBS for an explanation as to why it was now being applied to my deductible, that I had followed the direction of BCBS in July and that my auto insurance case had been closed. In that conversation, the BCBS representative told me to do nothing that my July 2014 EOB was correct and she would have it submitted. December EOB came, I called BCBS again and

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<sup>2</sup> The Petitioner also received services in the emergency room but that claim was resolved and is not an issue in this external review.

<sup>3</sup> BCBSM form no. 787B, approved 10/12.

during that conversation the BCBS representative advised me to appeal the decision.

If BCBS had guided me correctly in July, I could have turned the bill into my auto insurance for consideration. Each time I contacted BCBS regarding this claim I was trying to solve the problem before it got to this point. They misguided me 100%. If it was to be applied to our deductible, then in July and October 2014, I should have been told that. The mistake BCBS made should have been caught and the claim reprocessed correctly so that I could move forward with my auto insurance carrier. I trusted BCBS and what their representatives were guiding me to do.

### BCBSM's Position

BCBSM acknowledges that it made mistakes when it initially processed the claim for the ambulance service. It sent the Petitioner an explanation of benefit payments statement (EOB) dated July 11, 2014, saying the claim was filed too late by Thompsonville Ambulance:

This health care provider has a limited time to send us claims after the service date. We received this claim after the last day that we can review it for benefits. No amount was paid by us and you should not be billed.

But on May 15, 2015, in its response to the notice of this external review, BCBSM said that EOB was wrong:

This denial was inappropriate as the provider had 12 months to submit the claim and 24 months to submit a claim if it was initially submitted to the auto insurance carrier. Therefore, once the processing error was recognized, the claim was reprocessed to allow payment.

The claim was reprocessed for payment but not immediately. BCBSM first sent the Petitioner another EOB statement dated October 17, 2014, which showed the Petitioner responsible for the entire ambulance charge and had this message:

Our records show the patient has other primary insurance coverage. Please ask the provider to submit the claim to that carrier for review. If a balance remains, a claim may then be submitted to BCBSM for review.

Eventually BCBSM reprocessed the claim and sent the Petitioner an EOB dated December 12, 2014, that showed that the ambulance transport had been covered and that BCBSM's approved amount of \$661.84 was applied to the Petitioner's deductible. BCBSM explained its decision to the Petitioner's mother in its final adverse determination:

After review, our decision is maintained and the balance of \$661.84 remains a matter between you and the provider.

On the referenced date of service your family was covered under the *Simply Blue Group Benefits Certificate. Rider SBD-P \$4,000/\$8,000 Simply Blue Deductible*

*Requirement For Panel Services* amended your certificate to increase your annual deductible requirement for covered services by a panel provider to \$4,000 for one member and \$8,000 for a family...

I confirmed that on the referenced date of service, [the Petitioner] had not satisfied his panel provider deductible and the balance remains a matter between you and the provider.

While I understand your concerns regarding the service you received, BCBSM must process claims as they are submitted and in accordance to your group's health care benefits.

### Director's Review

The Director concludes that BCBSM in the end correctly processed the ambulance claim in accordance with the terms and conditions of the certificate and rider and on that basis upholds BCBSM's final adverse determination.

Ambulance transport is a benefit under the certificate (see pp. 5.5 - 5.6) and its necessity in this case is not disputed. Ambulance services are also subject to the annual deductible for panel services. The rider, which increased the annual deductible requirement for services from panel providers to \$4,000.00 for one member or \$8,000.00 for the family, says:

Your annual panel deductible will be imposed for most covered services except the following:

- Panel physician office visits. (The office visit charge will be subject to a flat-dollar copayment.)
- Services subject to a flat-dollar copayment requirement
- Presurgical consultations
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Hospice care benefits

Ambulance service is not one of the listed exceptions. Since there is no showing in the record that the panel deductible had been met at the time of the Petitioner's accident, the Director concludes that BCBSM correctly applied its approved amount to that deductible.

The Petitioner's mother argues that BCBSM's mistakes caused her to lose the opportunity to file a claim for the ambulance service with her automobile insurance carrier. In January 2015, as part of BCBSM's internal grievance process, she said:

In May of 2014 my auto insurance carrier called to inform me that the accident case would be closing and if we had any other claims to submit them promptly. I

went through all the bills I had received and everything had been submitted except an ambulance bill. I contacted Thompsonville Ambulance several times and it took 2 weeks for them to call me back. I spoke with a Jim and explained the situation. He had no record of the services. I told Jim the auto insurance case was being closed and that they had to submit their bill for the services immediately. Jim contacted me about 10 days later stating their accounting services had been notified.

In July of 2014 I received an explanation of benefits form from BCBS in which the claim had been denied with the statement below:

"This health care provider has a limited time to send us claims after the service date. We received this claim after the last day that we can review it for benefits. No amount was paid by us. And you should not be billed."

I called BCBS Customer Service Department and spoke with [REDACTED], asked why BCBS wasn't paying and [REDACTED] also made the above statement. I told [REDACTED] the auto accident case was being closed and that I wouldn't be able to submit any claims once it was closed and [REDACTED] assured me this was a contract rule that Thompsonville Ambulance has with BCBS and that they did not comply with the rule. That they have 6 months to submit their billing or they forfeit payment. That BCBS, nor I would be responsible after that point. I asked what I should do if Thompsonville Ambulance submitted a bill to me directly and [REDACTED] directed me to keep the July explanation of benefits form and if they billed me to send the bill back with a copy of the statement.

October's explanation of benefits arrived and the total cost \$712.50 for the ambulance bill was being passed off to me completely. I called BCBS customer services back on 11/4/14 and spoke with [REDACTED] who stated that the charges were being applied to my deductible. I explained to [REDACTED] what had previously been discussed in July with [REDACTED] and how unfair it was of BCBS to change their mind and that it was now too late for me to submit the bill to my auto insurance for payment. With further review of my account, [REDACTED] told me that the July statement was correct and that she would resubmit the claim, that my account was not ed and to keep my original paperwork. No worries.

December's explanation of benefits arrived and now BCBS has applied a discount but the remaining balance is still being passed off to me. On 1/5/15 I called BCBS customer services again and spoke with [REDACTED] . . . , after explaining all of this AGAIN, [REDACTED] went back through my account, seeing all the times I called, the issues that were discussed and after a very long time of being on hold, I was told that ambulance companies have 1 year to submit their billing and not the 6 months as was stated on my EOB and [REDACTED] in July. [REDACTED] said that because of this mistake in the 1 year rule, the charges were being applied to my deductible and that I needed to submit this appeal form. . . .

I feel the burden lies on BCBS. I was prompt in calling on the situation, there was time to have the charges resubmitted and then turned into my auto insurance company for payment. . . . I put forth the effort with both BCBS & Thompsonville Ambulance to get bills paid, I relied on BCBS for the proper advice on what to do and they failed. . . .

BCBSM ostensibly made two mistakes: It initially thought that the ambulance claim had been submitted too late, and then it assumed that another insurer was primary. Those two mistakes may have prevented the Petitioner from recovering benefits under his automobile insurance, although that is not clearly shown in the record. In any event, the Director, in this review under the Patient's Right to Independent Review Act (PRIRA), can only determine if BCBSM processed the claim for the ambulance transport under the terms and conditions of the certificate and rider. PRIRA does not give the Director the authority to amend or alter the terms of BCBSM's coverage because it made mistakes processing a claim.

The Director finds that BCBSM's decision to apply its approved amount of \$661.84 to the Petitioner's panel deductible was consistent with the terms and conditions of the certificate and rider.

**V. ORDER**

The Director upholds BCBSM's final adverse determination of March 2, 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:



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Randall S. Gregg  
Special Deputy Director