

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. 153514-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of June 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 3, 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.* The Director accepted the case for review on May 10, 2016. The review concerns a claim for air ambulance transportation.

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 LG*. The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. BCBSM provided its response on May 17, 2016.

The medical issues in this case were analyzed by an independent review organization, which submitted its report to the Director on June 10, 2016.

II. FACTUAL BACKGROUND

The Petitioner has a medical history of ulcerative colitis. Over a period of eight months, beginning in mid-2015, she was treated at Spectrum Health Butterworth Hospital in Grand Rapids. This treatment involved nonsurgical care. The Butterworth physicians suggested that the Petitioner might need surgery (a colectomy). The Petitioner declined to discuss surgery with the Butterworth staff. The Petitioner and her husband concluded, based on their own research,

that she should be evaluated at the Cleveland Clinic.

On March 26, 2015, the Petitioner travelled by ambulance from Butterworth Hospital to the Cleveland Clinic. The ambulance transportation was provided by Life EMS Ambulance, a provider that does not participate with BCBSM. The distance between the two hospitals is 302 miles. The amount charged by Life EMS Ambulance was \$4,285.00.

The Cleveland Clinic doctors concluded that surgery was needed and, on March 27, 2015, the Petitioner had a surgical procedure known as a total proctocolectomy with ileostomy placement. BCBSM provided coverage for the Petitioner's treatment at the Cleveland Clinic but declined to provide coverage for the ambulance transportation, having concluded that ambulance transportation was not medically necessary.

The Petitioner appealed the coverage denial through BCBSM's internal grievance process. At the conclusion of that process, on March 2, 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

Is BCBSM required to provide coverage for the Petitioner's ambulance transportation to the Cleveland Clinic?

IV. ANALYSIS

BCBSM's Argument

In the March 2, 2016 final adverse determination BCBSM stated:

At the time of service, you were covered under the *Simply Blue Group Benefits Certificate LG*. Page 19, (**Section 3: What BCBSM Pays For**), explains that 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. However, the ambulance service must be medically necessary because transport by any other means would endanger the patient's health. In this case, your ambulance services did not meet criteria as a medically necessary transport.

To ensure all consideration was given, an associate medical director, a board-certified M.D. in Internal Medicine, reviewed your claim, your appeal, and your health care plan benefits for BCBSM. Our medical consultant determined:

Upon review of the submitted documentation, medical management of your ulcerative colitis was no longer providing optimal outcomes and a surgical consultation was being recommended by the providers at

Spectrum during your March 2015 hospitalization. However, you refused this consultation and instead requested a second opinion at the Cleveland Clinic Foundation. An ambulance transfer to Cleveland Clinic was arranged by the providers at Spectrum. According to BCBSM medical policy, "Ambulance Services," the transport must be medically necessary, meaning transport by any other means would endanger your life and you are being transported to the nearest facility equipped to provide necessary care at that time. In this case, criteria for transport was not met.

Based on the medical consultant's determination that the ambulance services provided do not meet criteria for a medically necessary transport, together with the terms of your coverage stating that ambulance services must be medically necessary to be covered, we must maintain our position.

Petitioner's Argument

In the request for external review, the Petitioner wrote:

I am seeking to have Blue Cross Blue Shield of Michigan to pay for an ambulance ride. Spectrum Health made pre-approval arrangements to transport me to Cleveland Clinic. I was given approval to go to Cleveland. Months later BCBS retracted their payment. I was unable to travel by any other means of transportation.

In addition, the Petitioner submitted a lengthy narrative of her medical care during the time period in question. The Petitioner also submitted medical records of her treatment at Spectrum Health Butterworth Hospital

Director's Review

BCBSM's *Simply Blue Group Benefits Certificate*, page 17, states that any medical service, in order to be covered by BCBSM, must be medically necessary:

Services provided in accordance with the terms of this certificate are covered services only when they are medically necessary.

The certificate defines medical necessity:

A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

* * *

Medical necessity for payment of services of other providers:

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician....

With respect to ambulance services, the certificate, on page 19, provides:

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.

At issue in this appeal is whether it was medically necessary for the Petitioner to have been transported by ambulance to the Cleveland Clinic on March 26, 2015. Under section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6), questions of medical necessity are reviewed by an independent review organization. In this case, the reviewer is a physician in active practice for more than 15 years who is board certified in internal medicine and gastroenterology. The reviewer is familiar with the medical management of patients with the Petitioner's condition. The reviewer's report included the following analysis:

The member was evaluated and treated at Spectrum Healthcare and it was recommended that she needed to undergo a colectomy. The member's main problem on admission to Spectrum Health was nausea with vomiting resulting in hypovolemic hyponatremia. The member was not satisfied with the recommendation for surgery. Spectrum Health arranged for an ambulance ride to the Cleveland Clinic, which was 302 miles away, in order for the member to obtain a second medical opinion. This ambulance transportation took place on 3/26/15. At the Cleveland Clinic, the member ultimately underwent a total proctocolectomy with ileostomy placement. On the ambulance transportation sheet, the reason for transportation via ambulance was listed as "patient unable to sit for extended periods." Other reasons, such as need for oxygen, etc. were not checked. The member was described by the ambulance service records as weak and nauseous and was identified as being stable appearing and able to ambulate 20 feet to a cot to make herself comfortable.

[B]ased on the description from the ambulance service records on the day of transfer, it does not appear that ambulance transport was warranted. [T]he discharge summary from Spectrum Health also describes the member as stable. [T]he member did not require oxygen or have any other advanced treatment needs. [W]hile traveling more than 300 miles in the member's condition would not have been pleasant, a car ride would have been safe ... Spectrum Health could have arranged with the Cleveland Clinic to admit the member as a direct admission upon her arrival.

Pursuant to the information set forth above and available documentation ... it was

not medically necessary for the member to have been transported via ambulance to the Cleveland Clinic on 3/26/15. (Dejean D, et al. Inappropriate ambulance use: a qualitative study of paramedics' views. *Health Policy*. 2016 Feb;11(30:67-79. www.uptodate.com/contents/clinical-manifestations-diagnosis-and-prognosis-of-ulcerative-colitis-in-adults. (accessed 6/10/16).)

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the IRO's recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b).

The IRO's analysis is based on extensive experience, expertise, and professional judgment. The Director, discerning no reason why that analysis should be rejected in the present case, adopts the IRO analysis and finds that the Petitioner's ambulance transportation on March 26, 2015, was not medically necessary.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 4, 2016. BCBSM is not required to provide coverage for the Petitioner's March 26, 2015 ambulance transportation.

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:



Randall S. Gregg
Special Deputy Director