

**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. 154704-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 24<sup>th</sup> day of August 2016  
by Randall S. Gregg  
Special Deputy Director

**AMENDED ORDER**

On August 8, 2016, an Order was issued and entered in this case. However, the Director subsequently learned that the Petitioner had raised arguments that were mistakenly not included in the record when this case was reviewed and thus were not considered by the Director, specifically a letter from the Petitioner's authorized representative dated August 3, 2016, that was timely received.

In order to give consideration to those arguments, the Director withdraws the August 8, 2016, Order in its entirety and replaces it with this Amended Order.

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) required transport by air ambulance and was dissatisfied by the way his health insurer, respondent Blue Cross Blue Shield of Michigan (BCBSM), processed the claim for that service.

On July 20, 2016, ██████████, the Petitioner's authorized representative, filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On July 27, 2016, after a preliminary review of the information submitted, the Director accepted the case for review.

The Petitioner receives group health care benefits through a 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 responded on August 2, 2016. The Petitioner's authorized representative submitted additional information on August 3, 2016.

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 described in BCBSM's *Community Blue Group Benefits Certificate LG* (the certificate).

On January 10, 2015, the Petitioner was transported by rotary wing air ambulance from a hospital in Flower Mound, Texas, to another hospital in Denton, Texas, a distance of 14 miles. The transportation was provided by CareFlite, a Texas-based air ambulance service that does not participate with BCBSM or a local Blue Cross Blue Shield plan in Texas. The charge for the transport was \$26,066.60. BCBSM covered the transport but only paid \$6,513.08 to the provider.

The Petitioner, believing BCBSM should pay more, appealed through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated May 20, 2016, affirming its decision. The Petitioner now seeks the Director's review of that final adverse determination.

## III. ISSUE

Is BCBSM required to pay any additional amount for the Petitioner's air ambulance transport?

## IV. ANALYSIS

### BCBSM's Argument

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

. . . After review I confirmed the maximum payment available of \$6,513.08 was issued to CareFlite. Additional payment cannot be approved.

\* \* \*

Our reimbursement of \$6,513.08 for the January 10, 2015 air ambulance services is the full approved amount for procedure codes J7611 (albuterol; inhalation solution), A0431 (ambulance service, air (helicopter) service, transport, one way), A0436 (rotary wing air mileage, per statute mile), and A0422 (amb (als/bls) oxygen / oxygen supplies life sustaining situation).

The services in question were reported by CareFlite. This provider does not participate with Blue Cross Blue Shield (BCBS). Page 157 of the Certificate explains, nonparticipating providers are physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full.

While I empathize with your situation, we must administer your benefits in accordance to the terms of your coverage. The air ambulance services you received were approved because the services were part of emergency care. As a result, the claim processed in our in-network benefit level and we issued our maximum reimbursement of \$6,513.08 to the provider. Additional payment cannot be approved.

### Petitioner's Argument

In an August 3, 2016, letter the Petitioner's authorized representative made these arguments:

**1. BCBSM's reimbursement is inconsistent with [the Petitioner's] coverage under his Community Blue Group Benefits Certificate.**

[The Petitioner's] air ambulance transportation is a covered out-of-network service as defined in the Certificate. Therefore, the maximum out-of-pocket expense [he] is responsible for regarding his air ambulance transportation is \$1,250.

Page 22 of the Certificate addresses transportation by air ambulance. *Section 3: What BCBSM Pays For* provides the following:

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.

#### 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
- No other means of transportation are available, or the patient's condition requires transport by air rather than ground ambulance
- The patient is transported to the nearest facility capable of treating the patient's condition and
- The provider is licensed

[The Petitioner's] air ambulance transport meets all of the air ambulance requirements set forth in the Certificate and is therefore a covered service. First, the use of the air ambulance was medically necessary due to [his] condition (i.e., heart attack) and was ordered by his attending physician. Second, the severity of [his] condition required him to be transported by air rather than ground ambulance. Third, [he] was transferred to the nearest facility capable of treating his condition. . . . Fourth, the air ambulance provider, CareFlite, is licensed as an air ambulance service and is not a commercial airline.

Page 18 of the Certificate addresses out-of-pocket maximums for out-of-network covered services. *Section 2: What You Must Pay* provides:

Your annual out-of-pocket maximum per year for covered out-of-network services is:

- \$1,250 for one member
- \$2,500 for the family

CareFlite's air ambulance transport is a covered out-of-network service under the Certificate. Therefore, the maximum out-of-pocket expense [the Petitioner] is responsible for regarding the same is \$1,250.

**2. BCBSM's reimbursement is in violation of the Patient Protection and Affordable Care Act's federal regulations governing minimum payments for emergency services.**

Under the Patient Protection and Affordable Care Act ("ACA"), if a health insurance plan participant receives emergency services from a provider that is not in the health plan's network, limits on coverage may not be more restrictive than those applied to in-network providers. Further, the ACA requires the health care provider to pay a reasonable amount before a patient becomes responsible for a balanced billing amount as determined by an objective standard. This standard is known as the "greatest-of-three" methodology. . . .

Despite multiple requests, BCBSM has failed to disclose the methodology it used to calculate its maximum reimbursement of \$6,513.08. Therefore, [the Petitioner] requests that BCBSM provide verifiable data it used to calculate the (1) in-network amount; (2) usual, customary, and reasonable amount; and (3) Medicare amount for the air ambulance services. We are confident that upon further review, BCBSM will be required to pay more than its proposed reimbursement for the air ambulance transportation under the ACA's greatest-of-three standard.

### Director's Review

Ambulance service is a covered benefit under the certificate (p. 22). There is no dispute that the Petitioner met the criteria for the service. The only dispute is over the amount paid by BCBSM.

The certificate (p. 20) says that BCBSM pays its "approved amount" for covered services, including ambulance transport. "Approved amount" is defined in the certificate (p. 142) as

[t]he 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.

In this case, BCBSM's maximum payment level for the air ambulance service was \$6,513.08. Because that amount is lower than the billed charge from CareFlite, it became BCBSM's approved amount.

BCBSM pays its approved amount to both participating and nonparticipating providers. There is nothing in the certificate that requires BCBSM to pay more than its approved amount, even if the service is provided on an emergency basis, or if there was no participating provider available, or if the patient had no choice in which provider was used. BCBSM paid its full approved amount for the ambulance service and is therefore not required to pay any additional amount.

CareFlite is not a participating provider, i.e., it has "not signed a participation agreement with BCBSM to accept the approved amount as payment in full" (certificate, p. 158). Consequently, CareFlite may bill the Petitioner for any difference between what BCBSM pays and its charge. The certificate (p. 8) explains this:

Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, copayment and coinsurance as payment in full for covered services. Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount.

The Petitioner argues that BCBSM's payment level is inconsistent with the terms of his coverage because he has a maximum out-of-pocket expense for out-of-network services. The certificate (p. 18) says that the out-of-network out-of-pocket maximum is reached by combining all deductibles, copayments, and coinsurance paid by the Petitioner for covered out-of-network services during a calendar year. It is not the maximum amount that the Petitioner has to pay when services are received from a non-network provider whose charge exceeds BCBSM's approved amount (Balance Billed Amount). There is nothing in the record to show that the out-of-network out-of-pocket maximum was reached.<sup>1</sup>

The Petitioner also argues that the federal Patient Protection and Affordable Care Act governs the amount that BCBSM must pay for air ambulance transport, citing federal regulations at 45 CFR § 147.138(b) regarding the provision of emergency services. However, the Petitioner's arguments are not pertinent. Those regulations only apply to "services in an emergency department of a hospital."<sup>2</sup> The term "emergency services" as defined in the regulations means services in the emergency department of a hospital, not air ambulance transport.<sup>3</sup> Similarly, the Petitioner's "greatest of the three" argument is also inapposite because it only applies only to emergency services in a hospital.<sup>4</sup>

The Director finds that BCBSM's payment of \$6,513.08 for the Petitioner's January 10, 2016, air ambulance transport was in accord with the terms and conditions of the certificate.

## V. ORDER

The Director upholds BCBSM's final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any

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<sup>1</sup> The August 28, 2015, explanation of benefit payments statement indicates that the out-of-network out-of-pocket maximum is \$24,000.00 and that only \$63.83 had been applied as of that date for the calendar year 2015.

<sup>2</sup> 45 CFR § 147.138(b)(1).

<sup>3</sup> 45 CFR § 147.138(b)(4)(ii) and 42 U.S.C. § 300gg-19a(b)(2)(B).

<sup>4</sup> 45 CFR § 147.138(b)(3)(i).

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 'RSG', written over a horizontal line.

Randall S. Gregg  
Special Deputy Director