

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. 154826-001-SF

Washtenaw County, Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

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

ORDER

I. PROCEDURAL BACKGROUND

On July 28, 2016, ██████████, authorized representative of his spouse ██████████ (Petitioner), filed a request for an external review with the Department of Insurance and Financial Services. The request for review concerns the amount paid for ambulance services provided to the Petitioner in March 2016. The claim decision was issued by Blue Cross Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan.

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952) The Petitioner's health benefit plan is such a governmental self-funded plan. The plan's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC* (the certificate).

On August 4, 2016, after a preliminary review of the information submitted, the Director accepted the request for review. The Director notified BCBSM of the appeal and asked it to provide the information used to make its final adverse determination. BCBSM submitted its response on August 11, 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

On March 31, 2016, the Petitioner was transported seven miles by ambulance to [REDACTED] in Amarillo, Texas. The ambulance service was provided by American Medical Response Ambulance Service (AMR). The amount charged was \$1,434.52. BCBSM approved and paid \$511.34. AMR billed the Petitioner for the \$923.18 remaining balance.

The Petitioner appealed the amount paid by BCBSM through its internal grievance process. At the conclusion of that process, on June 23, 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 pay an additional amount for the Petitioner's ambulance transport?

IV. ANALYSIS

BCBSM's Position

In its final adverse determination to the Petitioner's husband, BCBSM stated:

The claim for [Petitioner's] ambulance service processed at the in-network benefit level. BCBSM paid 100 percent of the approved amount (\$511.34) to American Medical Response Ambulance Service. We pay the approved amount for covered services. Because American Medical Response Ambulance Service is a non-participating provider, they may choose not to accept our approved amounts as payment in full. We have issued the maximum payment for this service. Any balance between our approved amount and the total charge remains a matter between you and the provider.

[Petitioner] is an eligible dependent covered under the Community Blue Group Benefits Certificate ASC. Page 9 of the Certificate explains that your coverage utilizes a Preferred Provider Organization (PPO) provider network, and that your payment responsibility is determined by the participation level of the provider who delivers your services. Page 9 of the Certificate also states:

A provider can either be participating or non-participating.

Participating providers cannot bill you for more than our payment plus what you pay in cost-sharing. Nonparticipating providers can bill you for the amount that is more than what we pay plus out-of-network cost-sharing.

* * *

I confirmed that American Medical Response Ambulance Service is out-of-network and does not participate with Blue Cross Blue Shield. To clarify, while the claim did process at the in-network benefit level, because the provider is non-participating, any balance in excess of the approved amount remains an issue between you and the provider.

Petitioner's Position

In a letter dated July 26, 2016 accompanying the request for an external review the Petitioner and her husband wrote:

The purpose of this letter is to appeal the decision made by Blue Cross Blue Shield of Michigan to not pay for services provided by American Medical Response Ambulance Service contrary to the provisions outlined in my contract in the amount of \$923.18.

I have included a copy of the information that was downloaded from the "my coverage" section of my contract that specifically states that out of network ambulance services is 100 percent covered.

Please review this matter and direct BCBS of Michigan to repay us or make payment to the American Medical Response ambulance company. Please note that in order to avoid being sent to a collection agency, we paid for the services. Also, they offered and we accepted a reduced fee by 20 percent if we paid for the service in full.

Director's Review

Ambulance transport is a covered benefit under the Petitioner's health plan. According to the certificate (page 19), BCBSM pays its "approved amount" for covered services. "Approved amount" is defined in the certificate (page 140) 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.

BCBSM's maximum payment level for the Petitioner's ambulance transport was \$511.34. Because that amount is lower than the provider's billed charge of \$1,434.52, it became BCBSM's approved amount for the service.

AMR is not a BCBSM participating provider because it has "not signed a participation agreement with BCBSM to accept the approved amount as payment in full" (certificate, page 156). Consequently, AMR may bill the Petitioner for the difference between BCBSM's approved amount and its charge. The *Community Blue* certificate, on page 9, includes this provision:

*Important: A provider can either be participating or nonparticipating. Participating providers cannot bill you for more than our payment plus what you pay in cost-sharing. Nonparticipating providers can bill you for the amount that is more than what you pay plus out-of-network cost-sharing.

In this case, BCBSM paid its full approved amount¹ for the Petitioner's ambulance services and is not required to pay any additional amount. The Director finds that BCBSM's payment for the Petitioner's March 31, 2016 ambulance transport services was in accord with the terms and conditions of the *Community Blue* 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 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

¹ The Petitioner noted that her online contract said out-of-network ambulance services were payable at 100%. While this may be true, the Director notes this is only an online system where the member may access general information regarding their benefits and is not the contract (certificate). This system also includes a disclaimer which states: "Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders... If there is a discrepancy between the Benefits-at-a-Glance and any applicable plan document, the plan certificate will control."