STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXX
Petitioner **File No. 87127-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 8th day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 9, 2008, XXXX, authorized representative of his son XXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on January 16, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on January 29, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Group Conversion Comprehensive Health Care Benefit Certificate (the certificate). The Commissioner 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 sustained two fractures of his jaw and required emergency surgery to repair them using a metal plate. The surgery was performed on September 25, 2007, by XXXX, DDS, a non-participating provider. BCBSM paid $1,213.89 of the $4,576.00 charged by Dr. XXXX leaving the Petitioner to pay the balance of $3,362.11.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on December 5, 2007, and issued a final adverse determination December 11, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgery provided the Petitioner on September 25, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner was treated for his jaw fracture at XXXX on an emergency basis. Dr. XXXX was the only surgeon on call at the time. In addition, the Petitioner says BCBSM told him there were no participating oral surgeons in the area. The Petitioner's father said he contacted BCBSM twice and was told to go ahead with the surgery and that BCBSM "would stand behind us in this situation with an emergency waiver." The Petitioner's father had to pay Dr. XXXX's charge of $4,576.00 upfront.

The Petitioner's father says he was also told that BCBSM's average payment for the surgery (procedure code 21462) was $1,800.00, but BCBSM only paid $1,213.89 of the charge. The Petitioner is seeking "a more reasonable payment or payment in full as indicated by the BCBSM representative prior to surgery."

BCBSM's Argument

The amounts charged by Dr. XXXX and the amounts paid by BCBSM for the Petitioner's surgery are set forth in this table:

Procedure Code	Amount Charged	BCBSM's Approved Amount	Petitioner's Balance
21462	$4,576.00	$1,213.89	$3,362.11

Section 3 of the certificate, *Coverage for Physician and Other Professional Services,* explains that BCBSM pays an "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full.

BCBSM says it paid the same amount it would have paid to a participating surgeon; no deductibles or copayments were applied. However, since Dr. XXXX does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

BCBSM says the certificate does not require it to pay more than its approved amount even in cases of medical emergency. BCBSM believes that it has paid the proper amount for the Petitioner's care by a nonparticipating provider and is not required to pay any additional amount.

BCBSM also says there is no record to substantiate the exact nature of the Petitioner's father's discussions with BCBSM. In any event, BCBSM does not believe that the telephone conversations obligate it to pay more than its approved amount for the surgery.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." To determine the maximum payment level for each covered service, BCBSM applies the Resource Based Relative Value Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing

technology, training, and medical practice. In this case, the maximum payment level is less than the provider's charge and so it is BCBSM's approved amount for the Petitioner's surgery. BCBSM paid its full approved amount for the Petitioner's surgery; no deductible or copayment was applied.

Participating providers agree to accept BCBSM's approved amount as payment in full for their services. Nonparticipating providers, like Dr. XXXX, have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The certificate says (on page 3.20):

> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

It is unfortunate that the Petitioner was in a situation where he was not able to use a participating surgeon. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to a nonparticipating provider even if the services were provided on an emergency basis or no participating provider was available.

The Petitioner's father believes that BCBSM misinformed him about the amount it would pay for his surgery; BCBSM disputes that contention. However, the Commissioner cannot resolve the kind of factual dispute described by the Petitioner because the Patient's Right to Independent Review Act (PRIRA) lacks the hearing procedures necessary to make credibility determinations and findings of fact arising out of oral statements. Moreover, the Commissioner is without authority (which the circuit courts posses) to order relief based on doctrines such as estoppel and waiver. Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of December 11, 2007 is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care provided by Dr. XXXX.

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 sixty 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. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.