

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 101139-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 24th day of February 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 3, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* The initial request was incomplete. After additional information was provided, the Commissioner accepted it on November 20, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received Blue Cross Blue Shield's (BCBSM's) response on November 24, 2008.

The Petitioner is enrolled for health coverage through PET/ City of XXXX, an underwritten group. The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's Community Blue Group Benefits Certificate (the certificate). Rider CB-CM-NP \$5,000, Community Blue Copayment Maximum for Nonpanel Services (the rider), also applies. 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

On September 14, 2007, the Petitioner underwent bilateral blepharoplasty surgery provided by XXXXX, MD, a nonparticipating and non-PPO-panel surgeon. The surgery was performed in the surgeon's office and the charge was \$8,400.00. BCBSM's approved amount for the surgery was \$1,201.21. The entire approved amount was applied to the Petitioner's out-of-network deductible.

The Petitioner appealed BCBSM's decision. BCBSM held a managerial-level conference on October 9, 2008, and issued a final adverse determination dated October 16, 2008.

III ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's September 14, 2007, surgery?

IV ANALYSIS

Petitioner's Argument

The Petitioner had bilateral blepharoplasty surgery on September 14, 2007, and says BCBSM has failed to pay any of the \$8,400.00 charged for this care. According to the Petitioner, BCBSM indicated at first that improper codes were filed for this surgery; later it said the claim was denied because of a lack of information.

The Petitioner argues that her surgery was medically necessary and is a covered benefit under her certificate and BCBSM is required to pay for it.

BCBSM's Argument

BCBSM says that page 4.2 of the certificate clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is defined as the lesser of the provider's charge or BCBSM's maximum payment level for the service. The certificate does not guarantee that charges will be paid in full. Moreover, since the surgeon in this case does not participate with

BCBSM, he is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between its charge and BCBSM's payment.

The amounts charged by the surgeon and the amounts paid by BCBSM are listed in the following table:

Procedure	Procedure Code	Amount Charged	BCBSM's Approved Amount	Applied to Nonpanel Deductible	BCBSM Payment
Upper Lid Blepharoplasty	15823-50	\$3,400.00	\$1,201.21	\$1,201.21	-0-
Surgical Supplies*	A4649	\$3,000.00	-0-		-0-
Anesthesia by Surgeon**	00160	\$2,000.00	-0-		-0-
Totals		\$8,400.00	\$1,201.21	\$1,201.21	-0-

* Supplies provided by the surgeon are included in payment for the surgery

** Anesthesia is included in the surgeon's payment when provided by the surgeon

BCBSM says separate reimbursement for supplies is not available. BCBSM indicates that consideration for surgical supplies was included in the allowance for the surgical procedure and that the documentation provided did not establish that the supplies used were over and above those usually included with CPT code 15823. Also, on page 4.5 of the certificate it says, "If the operating physician gives the anesthetics, the service is included in our payment for the surgery." Therefore, only the surgeon's charge was considered for payment by BCBSM and it was limited to BCBSM's approved amount for the procedure.

BCBSM further says that since the surgeon is also not part of the PPO network and the Petitioner did not receive a written referral from a PPO physician, the approved amount for the surgery was applied to the nonpanel deductible. The rider requires a \$5,000 deductible for services provided by nonpanel providers.

BCBSM contends that it has correctly covered the claim for the Petitioner's surgery and is not required to pay more.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from PPO panel members or from other providers who participate with BCBSM. The surgeon that provided the Petitioner's care on September 14, 2007, is neither part of the PPO panel nor a participating provider with BCBSM. The certificate has sanctions when nonpanel providers are used. The certificate warns enrollees (page 4.29):

If the nonpanel provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial. * * *

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.

The certificate describes how benefits are paid when services are received from a nonparticipating provider. First, BCBSM only pays its "approved amount" for covered services -- it does not guarantee that the provider's charge will be paid in full. "Approved amount" is defined in the certificate as "the BCBSM maximum payment level or the provider's charge for the covered service, whichever is lower."

BCBSM's maximum payment level for a blepharoplasty is \$1,201.21. If Dr. XXXXX had participated with BCBSM, he would have accepted that amount as payment in full for his services even though his charge was \$3,400.00. However, nonparticipating providers are free to request payment for the difference between their charge and BCBSM's approved amount.

Because Dr. XXXX does not participate and he also is not a panel member, the approved amount for his services is also subject to the \$5,000.00 deductible. Thus, the \$1,202.21 BCBSM approved amount was applied to the nonpanel deductible.

In addition to the physician fee of \$3,400.00, the surgeon also charged \$3,000.00 for surgical supplies and \$2,000.00 for anesthesia. Under the terms of the certificate, a participating provider would not be permitted to charge extra for these services since they are considered to be included in the physician fee.

The Commissioner finds that the amount BCBSM approved for the Petitioner's surgery on September 14, 2007, is consistent with the provisions of her certificate and was properly applied to the nonpanel deductible. Therefore, BCBSM is not required to pay any amount to the Petitioner for her surgery.

**V
ORDER**

BCBSM's final adverse determination of October 16, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's September 14, 2007, surgery.

This is a final decision of an administrative agency. A 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 county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

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