

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. 101586-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 16th day of March 2009
by Ken Ross
Commissioner

ORDER

I

PROCEDURAL BACKGROUND

On November 21, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on December 2, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

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 Commissioner received BCBSM's response on December 9, 2008.

The Petitioner is enrolled for health care coverage as an eligible dependent through XXXXX County, a self-funded local government group. BCBSM administers the plan. The issue in this

external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate) which defines the Petitioner's health care benefits. 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 received services from XXXXX, DDS, from January through June 2007. The amount charged for this care was \$1,960.00. BCBSM denied payment because it believes it is not a covered benefit under the certificate.

The Petitioner appealed BCBSM's decision to deny coverage for the care provided by Dr. XXXXX. BCBSM held a managerial-level conference on August 13, 2008, and issued a final adverse determination dated October 9, 2008.

III ISSUE

Is BCBSM required to cover the Petitioner's care provided by Dr. XXXXX?

IV ANALYSIS

Petitioner's Argument

BCBSM has denied coverage for six office visits, an office consultation, and surgery provided by Dr. XXXXX because it believes it is orthodontic in nature. The Petitioner argues that her care should not be considered orthodontic care but medically necessary treatment before she can have surgery on her jaw.

Dr. XXXXX supports the Petitioner's position. He indicated the maxillary and mandibular interdental fixation devices were placed to provide a stable jaw position, and that treatment was not to the teeth but was orthopedic and neuromuscular in nature. According to Dr. XXXXX, this care was a continuation of the temporomandibular treatment and it was his opinion that it was medically necessary to achieve permanent orthopedic stabilization of the mandible and maintain the

orthopedic and neuromuscular position obtained to date. Dr. XXXXX said the treatment was a pre-surgical necessity and a key component of the surgical process.

The Petitioner argues that BCBSM should cover this treatment under her medical care certificate because it is medically necessary and not orthodontic care.

BCBSM's Argument

BCBSM cites provisions in the medical certificate as the basis for its decision. Section 4 of medical certificate, "Coverage for Physician and Other Professional Provider Services," has this language (page 4.23):

The following services are not payable:

* * *

- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization)

"Dental care" is defined in Section 7 of the medical certificate (page 7.6) as:

Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth. [Emphasis added]

In addition *Section 5: Coverage of Other Health Services*, states in part:

Temporomandibular Joint (Jaw Join) Dysfunction

We do not pay for medical and/or dental services performed for reversible or irreversible treatment of temporomandibular joint (jaw Joint) dysfunction, except for:

- Surgery directly to the temporomandibular joint (jaw joint)
- Diagnostic X-rays
- Arthrocentesis
- Physical therapy...

The Petitioner has medical and surgery coverage with BCBSM, not dental coverage, and therefore dental care under the certificate is very limited and specific. BCBSM says the records submitted by Dr. XXXXX show that orthodontic services were rendered to the Petitioner. Those

records did not establish that the Petitioner met any of the criteria for dental treatment under the certificate.

BCBSM says the care that is the subject of this review is not a covered benefit under the certificate and coverage was correctly denied.

Commissioner's Review

The Petitioner argues that her care from Dr. XXXXX should be covered under the medical certificate. However, that certificate has only very limited coverage for dental-related treatment; it is primarily for medical and surgical care.

The Petitioner says that the care was not simply orthodontic treatment but was required as part of the medically necessary treatment of her temporomandibular joint (TMJ) disorder. However, the certificate clearly says that treatment of TMJ problems is limited to the following: surgery directly to the jaw joint, diagnostic x-rays, arthrocentesis, and physical therapy. Orthodontic treatment that may be necessary in advance of jaw joint surgery is not covered.

The Commissioner finds that BCBSM has correctly denied coverage for the dental care at issue here since it is not a covered benefit under the certificate.

V ORDER

BCBSM's final adverse determination of October 9, 2008, is upheld. BCBSM is not required to pay for the Petitioner's orthodontic dental care.

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 Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.