

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. 102738-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 7th day of July 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 30, 2009, 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, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on February 6, 2009.

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 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 February 12, 2008.

The Petitioner is enrolled as an eligible dependent under her husband's health care coverage with the County of XXXXX, a self-funded local government group under Act 495. BCBSM

administers the plan. 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). 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 underwent post breast cancer breast reconstruction surgery on September 29, 2008. The surgery was performed by XXXXX, MD, a plastic surgeon. Dr. XXXXX does not participate with BCBSM

Dr. XXXXX charged \$9,880.00 for the surgery. BCBSM's approved amount was \$3,419.89, leaving a balance of \$6,460.11. Later, Dr. XXXXX agreed to a reduced balance of \$3,100.00.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on December 11, 2008, and issued a final adverse determination dated December 17, 2008.

III ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's September 29, 2007, reconstruction surgery?

IV ANALYSIS

Petitioner's Argument

The Petitioner was diagnosed with extensive ductal carcinoma in situ of the left breast. Her BCBSM participating doctor recommended a bilateral mastectomy and immediate breast reconstruction, and recommended that Dr. XXXXX do the reconstructive surgery.

The Petitioner determined that there are no BCBSM participating plastic surgeons within 150 miles of her home in XXXXX. Because of this and because she did not know the extent of her chemotherapy, she decided to have Dr. XXXXX do the surgery in spite of the fact he does not

participate with BCBSM.

The Petitioner argues that by using a local surgeon and not one in XXXXX, she avoided expensive trips to the emergency room if problems developed. In addition it would have been inconvenient and expensive for her to have follow-up visits in XXXXX.

The Petitioner believes that BCBSM should reimburse her the \$3,100.00 she was required to pay to Dr. XXXXX for her surgery.

BCBSM's Argument

BCBSM says that page 4.2 of the certificate clearly states that BCBSM's payment is based on an "approved amount" for covered services. The certificate does not guarantee that charges will be paid in full. The approved amount is defined in the certificate as the lesser of the provider's charge or BCBSM's maximum payment level for the service.

In determining the payment level for each service, BCBSM applies a Resource Based Relative Value Screen Scale (RBRVS). This is a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training and medical practice.

BCBSM says there is no difference in the amount it reimburses participating or non-participating providers. Participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM members. However, non-participating providers have no contractual obligation to accept the approved amount as payment in full, and consequently, they may bill a BCBSM member for the full balance after BCBSM's payment.

BCBSM states that there is nothing in the certificate that requires it to pay more than the approved amount even if no participating provider is available.

BCBSM contends that it has paid the proper amount for the Petitioner's surgery and is not required to pay more.

Commissioner's Review

The Petitioner had breast reconstruction from a plastic surgeon who, unlike other types of health care providers in her locality, does not participate with BCBSM. Because there were no participating plastic surgeons available nearby, she believes BCBSM should pay more than it has paid for her surgery.

It was not unreasonable for the Petitioner to want her surgery performed by a surgeon near her home. However, under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from providers who participate with BCBSM. The certificate (page 4.29) warns enrollees about using nonparticipating providers:

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 nonpanel and nonparticipating provider.¹ BCBSM only pays its "approved amount" for covered services; the certificate 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.

The amounts charged by the doctor and the amounts paid by BCBSM are shown in this table:

Procedure Code	Description	Amount Charged by Nonparticipating Physician	Approved Amount for Service	BCBSM's Payment
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¹ Because Dr. XXXXX is a nonparticipating provider, he is also a nonpanel provider.

Procedure Code	Description	Amount Charged by Nonparticipating Physician	Approved Amount for Service	BCBSM's Payment
19357	Surgery Breast Reconstruction	\$7,600.00	\$2,922.99	\$2,922.99
19357	Technical Surgical Assistance	\$2,280.00	\$496.90	\$496.90
Totals		\$9,880.00	\$3,419.89	\$3,419.89

BCBSM has paid its approved amount for the Petitioner's reconstructive surgery. Nothing in the certificate requires BCBSM to pay more than the approved amount, even when, as in the case here, there is no panel or participating provider available nearby.

The Commissioner finds that the Petitioner's claim in this case was paid correctly based on the terms of the certificate.

V ORDER

BCBSM's final adverse determination of December 17, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's September 29, 2008 breast reconstruction 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.