

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. 103907-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 12th day of August 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 26, 2009, 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 April 2, 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 April 13, 2008, and additional information on July 29, 2009.

The Petitioner has health care coverage through his employer, the XXXXX, a self-funded 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). *Rider CBC 50% NP Community Blue Copayment Requirement 50% For Nonpanel Services* 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 August 3, 2008, while in XXXXX, the Petitioner experienced a fainting spell and went to the emergency room of a nearby hospital. He was treated in the emergency room and remained in the hospital overnight for observation. Dr. XXXXX, a cardiologist who provided some of the Petitioner's care, charged a total of \$3,375.00. Dr. XXXXX does not participate with BCBSM or any Blue Cross or Blue Shield plan in XXXXX. Because he does not participate with a Blue Cross or Blue Shield plan, Dr. XXXXX is also not a panel provider.

BCBSM eventually approved \$923.25 for Dr. XXXXX's care and, after applying a \$140.65 nonpanel sanction, paid the Petitioner \$782.60.¹ The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on January 26, 2009, and issued a final adverse determination dated February 4, 2009.

III ISSUE

Did BCBSM process and pay the correct amounts for the Petitioner's care provided by a nonpanel provider?

IV ANALYSIS

Petitioner's Argument

The Petitioner experienced an unexplained episode of syncope (fainting) on the morning of August 3, 2008. He contacted the office of his primary care physician and spoke with an on-call

¹ BCBSM reconsidered some of the nonpanel sanctions it initially applied. The \$782.60 payment represents BCBSM's final decision on the payment of the nonpanel services.

doctor who advised him to go to the nearest emergency room to be checked out.

The Petitioner investigated which hospitals in the area participated with Blue Cross and Blue Shield and selected XXXXX Hospital in XXXXX. He was admitted to the emergency room and was given several tests to determine if he was having a heart attack. The tests were inconclusive so he was not permitted to leave the hospital. Instead, Dr. XXXX placed him in observation overnight and scheduled additional tests the next day. The Petitioner had an angiogram on August 4, 2008, which was negative.

The Petitioner says that he had no control over the fact that Dr. XXXXX did not participate with Blue Cross and Blue Shield and no opportunity to leave the hospital to obtain care from another doctor. He further says that all the services in the emergency room visit and during his non-voluntary stay for observation and additional testing were part of the same emergency. Therefore, he wants BCBSM to fully cover all the services he received at XXXXX Hospital on August 3 and August 4, 2008.

BCBSM's Argument

BCBSM says the Petitioner received services from a nonpanel physician as part of his care in XXXXX. As such, those services are subject to Rider *CBC 50% NP*. The rider amends the certificate to increase the copayment for services provided by nonpanel doctors to 50%. The rider says that this copayment does not apply when:

- A panel provider refers you to a nonpanel provider
* * *
- **You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office**
- You receive services from a provider which has no PPO panel
- You receive services from a nonpanel provider in a geographic area in Michigan deemed a "low access area" by BCBSM for that particular provider specialty [Emphasis added]

BCBSM did not apply the 50% nonpanel copayment for much of the medical care the Petitioner received since it was part of the initial exam to treat the Petitioner's medical emergency. However, BCBSM argues that for procedures 99255, 93543, and 93545, the 50% copayment was applied because they were not part of the initial emergency exam.

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

In determining the maximum payment level for each service, BCBSM applies a 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, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM says it regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice.

BCBSM says 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, nonparticipating 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 or if the service is provided on an emergency basis.

Finally, BCBSM said when multiple related services are performed on the same day, it will pay its full approved amount for the more expensive service. Therefore, there was no consideration for the \$140.00 hospital discharge charge or for the \$20.00 rhythm ECG charge because they were

included in the reimbursement for other services performed on the same date and are not payable separately.

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

Commissioner's Review

The Petitioner wants BCBSM to pay additional amounts for the physician's care he received on August 3 and 4, 2008. He believes that all of the care provided during this time was to treat his medical emergency.

The certificate has this provision about coverage for emergency treatment (p. 4.9):

We pay for services of one or more physicians for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office. Follow-up care is not considered emergency treatment.

NOTE: Deductible and copayments are not required for these emergency panel or nonpanel physician services.

This provision makes clear that deductibles and copayments are not applied for emergency care from nonpanel physicians. This table shows the claims for Dr. XXXXX's services:

Date of Service	Procedure Code	Nomenclature	Charge	BCBSM's Approved Amount	Nonpanel Sanction (50% of Approved Amount)
8/3/08	71010	Chest X-ray	\$35.00	\$11.52	
8/3/08	71275	CT angioplasty, chest	362.00	97.83	
8/3/08	73130	X-ray of hand	33.00	11.09	
8/3/08	93307	Echo exam of heart	200.00	60.91	
8/3/08	93320	Doppler echo exam	175.00	25.42	
8/3/08	93325	Doppler color flow	175.00	5.02	
8/3/08	99255	Inpatient consultation	385.00	234.77	\$117.39
8/4/08	93510	Left heart catheterization	1,000.00	320.76	
8/4/08	93543	Injection for heart	200.00	19.32	9.69
8/4/08	93545	Injection for coronary	200.00	27.14	13.57

Date of Service	Procedure Code	Nomenclature	Charge	BCBSM's Approved Amount	Nonpanel Sanction (50% of Approved Amount)
8/4/08	93555	Imaging, cardiac cat	250.00	54.14	
8/4/08	93556	Imaging, cardiac cat	200.00	55.27	
8/4/08	93042	<i>Rhythm ECG, report</i>	20.00	0.00	
8/4/08	99238	<i>Hospital discharge</i>	140.00	0.00	
Totals			\$3,375.00	\$923.25	\$140.65

BCBSM applied the 50% nonpanel copayment to Dr. XXXXX's initial consultation on August 3 (99255) and two injections on August 4 (93543 and 93545). For all other services BCBSM paid its full approved amount.

The Commissioner disagrees with BCBSM's determination to apply the nonpanel sanction for procedures 99255, 93543, and 93545. The Commissioner finds that these services were related to the emergency. The Petitioner was required to remain in observation overnight for continued testing and therefore his emergency continued until the time he was discharged.

In its July 29, 2009, response to OFIR, BCBSM acknowledged that observation is not inpatient care. Therefore, BCBSM should not have applied the 50% nonpanel copayment to procedure code 99255 because it is for inpatient hospital observation or consultation and the Petitioner was never admitted as an inpatient. This code should have been corrected to reflect the appropriate outpatient or emergency procedure code.

With respect to procedure codes 93543 and 93545, they should not be subject to the nonpanel copayment because they were incidental to the heart catheterization procedure that was paid at the panel rate as part of the outpatient emergency care. The Commissioner finds that these services were part of the initial emergency treatment and therefore not subject to the nonpanel sanctions.

BCBSM did not pay for a rhythm ECG report or the hospital discharge charge because they are included in the reimbursement for other services provided to the Petitioner. Non-covered

services provided by a nonpanel provider remain the responsibility of the patient.

The certificate describes how benefits are paid when services are received from nonpanel and nonparticipating providers like Dr. XXXXX. 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 BCBSM’s maximum payment level or the provider’s charge for the covered service, whichever is lower.² 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 or the care was for a medical emergency.

The certificate (page 4.30) cautions 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.

Furthermore, a nonparticipating provider has no contractual obligation to accept the approved amount as payment in full, and consequently, may bill a BCBSM member for the full balance above BCBSM’s approved amount.

The Commissioner finds that the Petitioner’s claim in this case was paid correctly except for the application of the nonpanel sanctions.

V ORDER

BCBSM’s final adverse determination of February 4, 2008, is reversed in part. BCBSM shall provide coverage for procedures 99255, 93543, and 93545 without applying the nonpanel sanctions and reimburse the Petitioner for an additional \$140.65.

BCBSM shall provide coverage within 60 days of the date of this Order and shall, within seven days of providing coverage, provide the Commissioner with proof it has implemented this

² Since the Petitioner’s care was received in California, BCBSM used the maximum payment levels of the XXXXX Blue

Order. To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

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.