

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

XXXXX

Petitioner

File No. 85852-001-SF

v

Blue Cross and Blue Shield of Michigan
Respondent

_____ /

Issued and entered
This 27th day of November 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 22, 2007, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it for external review on October 29, 2007.

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 (PRIRA), 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 November 6, 2007.

The Petitioner is enrolled for health coverage with BCBSM through the Michigan Public School Employees Retirement System (MPSRS), a self-funded group. The issue in this external

review can be decided by a contractual analysis. The contract involved here is the MPSERS/BCBSM *Your Benefit Guide* (the guide). 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 May 10, 2007, the Petitioner was admitted to XXXXX in XXXXX after a motor vehicle accident caused by a fainting episode. Cardiac evaluation revealed that he had significant coronary artery disease. He had a heart catheterization on May 14, 2007, and on May 16, 2007, he underwent a coronary artery bypass. The procedures were performed by XXXXX, MD, of XXXXX. XXXXX is a nonparticipating provider (i.e., it has not signed an agreement to accept BCBSM's approved amount as payment in full.)

BCBSM paid \$3,296.83 of the \$7,550.00 charged for the surgery. This left the Petitioner to pay the balance of \$4,253.17.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on September 4, 2007, and issued a final adverse determination dated September 10, 2007.

III ISSUE

Is BCBSM required to pay an additional amount for the surgery provided the Petitioner by Dr. XXXXX on May 16, 2007?

IV ANALYSIS

Petitioner's Argument

The Petitioner was admitted to the emergency room of XXXXX on May 10, 2007, after his automobile accident. He received tests to find the cause of the blackout while driving and was found to have severe coronary artery disease. He had two arteries with 100% blockage, another

with a 90% blockage, and a fourth with an 80% blockage. The blockages irritated his heart, caused it to go out of rhythm, and the blackout occurred.

The Petitioner says that he was in the hospital for an emergency when he had his bypass surgery and that the surgery was the treatment for his loss of consciousness. The Petitioner argues that since the surgery was for an emergency condition, it is a covered benefit under the guide.

The Petitioner also says that not only is XXXXX the only group of cardiothoracic surgeons in XXXXX, it is the only group within seventy miles who could perform his surgery.

The Petitioner argues that BCBSM is required to pay the full amount charged for his surgery by the out-of-network provider because it was treatment for an emergency condition and no other surgeons were available.

BCBSM's Argument

The amounts charged by the surgeon and the approved amounts paid by BCBSM for the May 16, 2007, surgery, are set forth in this table:

Procedure Code	Amount Charged	BCBSM's Maximum Payment Amount	BCBSM's Approved Amount	Amount Paid by BCBSM	Petitioner's Balance
33533	\$ 5,000.00	\$2,409.67	\$2,409.67	\$2,409.67	\$2,590.33
33518	\$ 1,300.00	\$337.69	\$337.69	\$337.69	\$962.31
33533 (TSA)*	\$ 1,000.00	\$481.93	\$481.93	\$481.93	\$518.07
33518 (TSA)*	\$ 250.00	\$67.54	\$67.54	\$67.54	\$182.46
Totals	\$ 7,550.00	\$ 3,296.83	\$ 3,296.83	\$ 3,296.83	\$ 4,253.17

BCBSM says the guide does not guarantee that charges will be paid in full. Instead, it says BCBSM will pay its "approved amount" for physician's services. The approved amount is defined in the guide as the "maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider's charge for the covered service, whichever is lower."

* TSA stands for technical surgical assistance. TSA is assistance provided by another physician at the request of the operating surgeon. TSA is paid 20% of the approved amount of the procedure involved. Thus, for procedure 33533, 20% of \$2,409.67 is \$481.93, and for procedure 33518, 20% of \$337.69 is \$67.54.

To determine the maximum payment level for each service, BCBSM says it 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. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice.

The Petitioner has argued that his bypass surgery should have been covered because it was an emergency service, citing page 22 of the guide which lists examples of medical emergencies. However, BCBSM says the Petitioner failed to read another provision regarding emergency services on that same page, which says, "If a provider does not participate with Blue Cross Blue Shield, you also pay difference between the provider's charge and the Blue Cross-approved amount." A similar provision is also shown under "Surgical Services" on page 24. Since Dr. XXXXX and XXXXX do not participate with BCBSM, they are not required to accept BCBSM's approved amount as payment in full.

BCBSM also disputes the Petitioner's contention that Dr. XXXXX and XXXXX are the only cardiothoracic providers within seventy miles of the Petitioner's home. BCBSM says there are eleven in-network thoracic surgeons within the 70-mile radius of the Petitioner's home, and therefore, participating surgeons were available to him.

BCBSM further says that it overpaid for procedure 33518 because when two or more surgeries are performed during the same operating session, the second surgery is subject to a payment limitation of 50% of the approved amount. BCBSM says the \$337.69 it paid for procedure 33518 is 100% of its approved amount, not 50%, but it does not intend to ask for repayment of the amount it overpaid.

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.

Commissioner's Review

The guide 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 guide as the "maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider's charge for the covered service, whichever is lower." Participating and network providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

Under the circumstances of this case, BCBSM is not required to pay more than its approved amount for the Petitioner's surgery. It is unfortunate that the Petitioner's situation was such that he did not use a participating surgeon. Nevertheless, there is nothing in the terms and conditions of the guide that requires BCBSM to pay more than its approved amount to a nonparticipating provider -- even if no participating provider was available or even if the services were provided on an emergency basis.

The petitioner believes that his bypass surgery should be considered emergency care. This seems doubtful since it came six days after he went to the emergency room. However, BCBSM would still not have to pay more than its approved amount and the Petitioner would still be responsible for the difference between the out-of-network surgeon's charge and the approved amount even if the bypass surgery was an emergency service (see page 22 of the guide).

The Petitioner also seems to argue that because the services he received were "covered" under the guide they should be paid in full. However, all covered services are still subject to any payment limitations listed in the guide (deductibles, copayments, and the difference between the charge and BCBSM's approved amount in the case of an out-of-network provider performing the service).

BCBSM paid its approved amount for all the procedures provided to the Petitioner on May 16, 2007. The Commissioner finds that BCBSM has paid the Petitioner's surgery correctly according to the terms of the guide and is not required to pay more for his care.

**V
ORDER**

BCBSM's final adverse determination of September 10, 2007, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's May 16, 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 Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.