

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. 114678-

001

v

Blue Cross Blue Shield of Michigan
Respondent

_____ /

Issued and entered
this 16th day of February 2011
by Ken Ross
Commissioner

ORDER

I

PROCEDURAL BACKGROUND

On August 5, 2010, 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, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on August 12, 2010.

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 August 26, 2010.

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Nongroup Comprehensive Health Care Benefits Certificate* (the certificate). *Rider NG-DCP (Nongroup Deductible and Copayment Program)* 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 April 1, 2010, the Petitioner had surgery performed by Dr. XXXXX. Dr. XXXXX does not participate with BCBSM. The amounts charged by the surgeon and the amounts paid by BCBSM are shown here:

Procedure Code	Procedure	Surgeon's Charge	BCBSM's Approved Amount	Petitioner's 30% Copayment	Amount Paid by BCBSM
12034	Wound closure	\$ 370.00	\$ 361.68	\$ 108.50	\$ 253.18
11406	Excision of lesion	440.00	176.45*	52.94	123.51
Totals		\$ 810.00	\$ 538.13	\$ 161.44	\$ 376.69
* BCBSM's approved amount for a secondary surgery performed on the same date is reduced by 50%					

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on June 29, 2010, and issued a final adverse determination dated July 9, 2010.

III ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's surgery under the terms of the certificate?

IV ANALYSIS

Petitioner's Argument

On March 25, 2010, the Petitioner had a lesion removed from her abdomen and afterwards the surgeon closed the wound using stitches. BCBSM counted the wound closure as a second surgery and reduced its approved amount by 50%.

The Petitioner believes that BCBSM is required to pay its full approved amount for both procedures that were part of her March 25, 2010, surgery.

BCBSM's Argument

BCBSM says that its payment for a service (its "approved amount") is based on the lesser of the provider's charge or BCBSM's maximum payment level. To determine its maximum payment level, BCBSM applies a resource based relative value screen (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 covers surgery using a national standard that pays 100% of the approved amount for the primary procedure (in this case, CPT code 12034) after the 30% copayment is applied, and 50% of the approved amount for a secondary procedure (CPT code 11406) when it is performed during the same operative session.

BCBSM also takes into consideration any unusual circumstances or medical complications that arise in connection with a particular surgery or medical procedure in determining reimbursement. In this instance, additional reviews were done by a BCBSM medical consultant, and it was determined that the Petitioner's claim was paid appropriately. BCBSM's consultant did not see any extenuating circumstances to warrant additional payment for the procedures performed.

BCBSM notes that there is no difference in the amount BCBSM reimburses participating and non-participating providers, and there is nothing in the certificate that requires BCBSM to pay more than its approved amount to a nonparticipating provider, even if no participating provider was available. Participating and nonparticipating providers receive BCBSM's approved amount. The difference is that participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services. Nonparticipating providers, on the other hand, may not accept BCBSM's approved amount as payment in full and consequently

choose to bill for any balance owed.

BCBSM argues that it has paid the appropriate amount for the Petitioner's care as required by the certificate.

Commissioner's Review

On p. 3.3, the certificate has this provision dealing with multiple surgeries:

Multiple surgeries performed on the same day by the same physician are paid according to the national standards recognized by BCBSM.

When a subscriber has more than one procedure by the same surgeon on the same day, BCBSM applies a national standard that pays the full approved amount for the primary procedure and one-half the approved amount for the secondary procedure. This is done because there are savings of time and effort when a procedure is done in conjunction with other procedures, e.g., there is a need to prep the patient only once.

This national standard is used by many health plans and is consistent with the certificate language. BCBSM determined that its approved amount for the Petitioner's surgery was \$538.13. This is based on the full approved amount for procedure code 12034 (\$361.68) and one half the maximum amount for procedure code 11406 (\$176.45). In addition, the Petitioner's health plan includes Rider NG-DCP which requires a copayment of 30% of the approved amount of covered services. BCBSM applied a 30% copayment to \$538.13 and paid \$376.69 to the Petitioner. The Commissioner concludes that BCBSM correctly covered the Petitioner's surgery on March 25, 2010.

Nonparticipating providers like Dr. Saunders have not agreed to accept BCBSM's approved amount as payment in full and may bill for any balance over the approved amount. The certificate (page 3.24) has this warning regarding nonparticipating providers:

You should expect to pay charges to a nonparticipating provider at the time you receive the services. You should then submit a claim to us. If we approve the claim, we will send payment to you.

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.

Thus, the Petitioner may be responsible for the balance of the surgeon's fee that is above BCBSM's approved amount.

The Commissioner finds that Petitioner's claims in this case were processed correctly under the terms and conditions of the certificate and BCBSM is not required to pay any additional amount

**V
ORDER**

BCBSM's final adverse determination of July 9, 2010, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's surgery.

This is a final decision of an administrative agency. Any 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.

Ken Ross
Commissioner