

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. 112537-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 23rd day of February 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 24, 2010, 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.* Act 495 authorizes the Commissioner to conduct external reviews for individuals with this type of coverage in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 12, 2010.

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 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 Federal Employees Program (FEP) provides Petitioner's primary health benefit coverage. The Petitioner also receives health care benefits as an eligible dependent under his wife's coverage with the XXXXX, a self-funded local government group. Respondent Blue Cross Blue Shield of Michigan (BCBSM) administers the XXXXX plan.

From October 2009 through April, 2010, the Petitioner received home infusion therapy services provided by XXXXX of XXXXX. After the FEP's coverage, Petitioner was responsible for copayments and deductibles of \$1,805.07. The Petitioner then filed a claim with his secondary carrier. BCBSM denied payment asserting that home infusion is not a covered benefit unless provided by a hospital.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on April 9, 2010, and issued a final adverse determination dated May 7, 2010, affirming its denial.

III ISSUE

Is BCBSM required to provide coverage for the Petitioner's home infusion therapy?

IV ANALYSIS

Petitioner's Argument

The Petitioner developed a life threatening infection after back surgery in September 2007. He had another surgery to remove the infected area. When he was sent home from the hospital he was placed on home infusion therapy. Additional home infusion therapy was ordered after another infection resulted in pneumonia in February of 2008. After yet another back surgery in March 2008, he was placed on home infusion therapy once again.

The Petitioner's secondary coverage under his wife's Community Blue certificate covers home infusion at 100%. For that reason, the Petitioner argues that the secondary coverage should pay the balance of his home infusion therapy.

The Petitioner believes that his care meets all the requirements of in home infusion therapy

set forth in the certificate: it was prescribed by the attending physician, was medically necessary and was performed by a BCBSM network home infusion therapy provider. Therefore, the Petitioner argues that BCBSM is required to pay for the \$1805.07 balance of his infusion therapy under the coordination of benefit provisions in the certificate.

BCBSM's Argument

BCBSM states that, while the home infusion care is covered under his primary insurance, it is not a covered benefit under the secondary coverage that BCBSM provides. In its May 7, 2010, final adverse determination BCBSM stated the reason why it concluded that home infusion care is not a covered benefit:

This benefit is part of the hospital/facility portion of your coverage. It is not a professional benefit. The procedure code in question is not payable when rendered by a "professional" provider such as XXXXX. The procedure may only be payable when billed by a hospital. Since this is not the case under your coverage, we are unable to approve COB for the claims in question and the balances remain your liability.

Commissioner's Review

The BCBSM *Community Blue* certificate of coverage includes one coverage provision for home infusion therapy. The provision appears in section 3 "Coverage for Hospital, Facility and Alternatives to Hospital Care." This provision is reprinted below:

Alternatives to Hospital Care

* * *

Home Infusion Therapy

This program provides coverage for home infusion therapy services whether or not you are confined to the home.

Services are limited only by the lifetime dollar maximum of this certificate. To be eligible for home infusion therapy services, your condition must be such that home infusion therapy is:

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if it can be safely managed in the home
- Medically necessary (as defined in Section 7)
- Given by **participating** home infusion therapy providers

Services include:

- Drugs required for home infusion therapy

- Nursing services needed to administer home infusion therapy and treat home infusion therapy-related wound care
* * *
- Durable medical equipment, medical supplies and solutions needed for home infusion therapy
* * *

We do not pay for services rendered by **nonparticipating** home infusion therapy providers.

Home infusion therapy services given by a participating BCBSM-approved home infusion therapy provider are considered panel services and will be subject to applicable deductible and copayment requirements for such services. [Emphasis in the original.]

BCBSM argued that it is not required to provide coverage as the secondary carrier for Petitioner's home infusion therapy since they were provided by a "professional provider" and not by a hospital.

Petitioner meets all three criteria to be eligible for home infusion therapy: his care is prescribed by a physician, it is medically necessary, and it is provided by a participating provider. BCBSM does not dispute the Petitioner's eligibility. Instead, BCBSM claims the therapy must be provided by a hospital in order to be covered. This requirement is not stated in the home infusion therapy provision itself (quoted above). BCBSM bases its argument on the fact that the home infusion therapy provision appears in a part of the certificate that appears in the "hospital/facility" section of the certificate, not in the "professional services" section. BCBSM's argument must be rejected. The actual section of the certificate that includes the home infusion therapy coverage is titled "Coverage for Hospital, Facility and Alternatives to Hospital Care." Thus the section is not limited to hospital provided services but also includes "alternatives to hospital care."

In addition, the actual language of the infusion therapy provision includes no indication that the therapy must be provided in, or by, a hospital. The provision includes only one exclusion, for "services rendered by nonparticipating providers." BCBSM's entire argument is based on its own interpretation of the title of a section of the certificate. That interpretation is not stated in the certificate, while every other clause of the infusion therapy section supports a conclusion that coverage is provided when administered by a participating provider.

In making a coverage determination, it is the actual language of the certificate that must prevail. The language of the coverage provision in this case is quite clear – when the conditions stated in the home infusion therapy provision are satisfied, coverage is provided so long as the provider is a BCBSM participating provider.

BCBSM is required to provide secondary coverage for the Petitioner's home infusion therapy.

V
ORDER

BCBSM's final adverse determination of May 7, 2010, is reversed. BCBSM is required to cover the Petitioner's home infusion therapy copayment and deductibles. BCBSM shall provide coverage within 60 days and, within seven days of providing coverage, provide proof it has implemented the Commissioner's 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. 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