

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. 111656-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 25th day of March 2011
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 28, 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 4, 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 12, 2010.

The Petitioner is enrolled for health care coverage with BCBSM through an underwritten group. His benefits are defined in the BCBSM *Community Blue Group Benefits Certificate* (the certificate).

The issue in this external review can be decided by a contractual analysis. 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

In November 2009 the Petitioner had spinal surgery and spent three days at XXXXX Hospital in XXXXX. BCBSM denied coverage for the hospital charges related to the surgery (\$178,360.95) on the basis that they were not covered under the terms of the certificate.

The Petitioner appealed BCBSM's denial. After a managerial-level conference on July 14, 2010, BCBSM did not change its position and issued a final adverse determination dated July 15, 2010.

III ISSUE

Is BCBSM required to cover the Petitioner's hospital care provided at XXXXX Hospital from November 25, 2009, to November 27, 2009?

IV ANALYSIS

Petitioner's Argument

The Petitioner says that he was pre-certified for this surgery by BCBSM through the hospital and the orthopedic surgeon's office. According to the Petitioner, BCBSM pre-approved the surgery and now refuses to pay the hospital.

The hospital, in a February 9, 2010, letter to BCBSM, said it made efforts to verify benefits and coverage on three occasions:

- 11-19-09 via Blue Cross Blue Shield website out of network benefits were cited as available and NO STIPULATIONS were given.
- 11-20-09 with your customer service representative "Cheryl," we were quoted out of network benefits with NO STIPULATIONS.
- 11-20-09 when we obtained authorization for [the Petitioner's surgery] from the aforementioned Cheryl again NO STIPULATIONS were mentioned.

The hospital says that at no time during its verification or pre-certification process was it told

by BCBSM that the out-of-network benefits were accessible only in an emergency or for an accident. The hospital believes that it did its due diligence in verifying coverage.

The Petitioner thinks BCBSM should pay for his hospital charges because he was misled to believe that it was a covered benefit.

BCBSM's Argument

Under the terms of the certificate, BCBSM does not cover services rendered in a nonparticipating facility (other than for a medical emergency or to treat an accidental injury).

In the Petitioner's case he received elective surgery at XXXXX Hospital. The hospital does not participate with BCBSM or any Blue Cross or Blue Shield plan.¹ Since the XXXXX Hospital is a nonparticipating facility and the Petitioner's services were not for an emergency, BCBSM says his hospital stay was denied appropriately.

Regarding the hospital's contention that the Petitioner's stay was pre-certified, BCBSM explained "pre-certification" to the Petitioner in its July 15, 2010, final adverse determination:

[We] realize that you feel that payment should be made because precertification was requested by the admitting facility and it was approved. However, precertification does not guarantee payment of the claim. Precertification is a required pre-service review for all inpatient admissions. It is based solely on clinical information, which is used to determine if the requested admission is medically necessary and appropriate according to medical guidelines. A service must be considered a "covered service" before a clinic review is honored.

BCBSM further said in the letter:

Please note that payment determinations are made upon receipt of the claim. Upon receipt of the claim, eligibility and benefit criteria (provider restrictions, location restrictions, diagnostic restrictions, cost sharing requirements, etc.) is [sic] applied prior to release of payment. Because a review of your files do not support that incorrect information was provided to you or your providers prior to receipt of the service, we must uphold our position.

BCBSM maintains it paid the Petitioner's care in accordance with the provisions of the

certificate.

1 The Petitioner's surgeon and anesthesiologist both participate with BCBSM and were reimbursed accordingly.

Commissioner's Review

A

In Section 3 of the certificate, under *How Hospitals, Facilities and Alternative to Hospital Care Providers are Paid* (p. 3.55) is says:

- If the provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial because BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency. [Underlining added]

In *Section 7: Language of Health Care*, the certificate (p. 7.17) defines the term “nonparticipating providers” as

Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. . . .

No information was provided to show that XXXXX Hospital has signed a participation agreement with BCBSM or any Blue Cross or Blue Shield plan. Thus, the hospital is by definition a nonparticipating hospital. The certificate is clear that care at a nonparticipating hospital is not covered unless it is care for an accidental injury or a medical emergency. The Petitioner does not contend that his surgery was needed because of an accident or an emergency. Therefore, the Commissioner concludes that the Petitioner's care at Oklahoma Spine Hospital is not a covered benefit under the certificate.

B

The Petitioner says that BCBSM misled him to believe that his hospital care was a covered benefit because it pre-certified the surgery and failed to inform the hospital that treatment in a nonparticipating facility was not a covered benefit. BCBSM disputes those assertions.

However, the Patients Right to Independent Review Act (PRIRA) does not permit the Commissioner to conduct the kind of fact-finding hearing that would be needed to resolve the Petitioner's contentions. PRIRA provides only for a very limited “paper” hearing. *English v Blue Cross Blue Shield of Michigan*, 263 Mich App 449 (2004). Moreover, the Commissioner must

adhere to the plain language of the certificate; he lacks the power, which the courts possess, to base a decision on doctrines such as misrepresentation or estoppel.

Under PRIRA, the Commissioner's role is limited to determining whether a health plan has correctly administered health care benefits under the terms of the applicable insurance contract and state law. The Commissioner finds that BCBSM's denial of the Petitioner's claim was consistent with the terms of the certificate. The Commissioner's decision here does not preclude the Petitioner from seeking other remedies available under applicable state law. See MCL 550.1915(3).

V
ORDER

BCBSM's final adverse determination of July 15, 2010, is upheld. BCBSM is not required to cover the Petitioner's care at XXXXX Hospital.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty 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. 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