

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 114547-

001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 28th day of April 2011
by R. Kevin Clinton
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 2, 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 9, 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 18, 2010.

The issue in this external review can be decided by a contractual analysis. The contracts that define the Petitioner's health care benefits are the BCBSM *Flexible Blue Individual Market Certificate* (the certificate) and *Rider ICB-OV* (the rider) which amends the certificate's provisions regarding office visits. 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 August, September, and October 2009, the Petitioner received care from doctors at the XXXXX. BCBSM denied coverage for this care, saying it was not a covered benefit.

The Petitioner appealed BCBSM's denial. BCBSM provided a managerial level conference and issued a final adverse determination dated June 24, 2010, upholding the denial.

III ISSUE

Did BCBSM correctly deny coverage for the Petitioner's care on August 27, September 28, and October 21, 2009?

IV ANALYSIS

Petitioner's Argument

The Petitioner treated with a surgeon from 2007 to the summer of 2009 and was eventually told that back surgery was necessary. She was referred to XXXXX, MD, at XXXXX. The surgery was performed on November 24, 2009.

The Petitioner says four visits were denied by BCBSM:

Date of Service	Provider	Amount Billed
08-19-09	XXXXX, MD (neurosurgeon)	\$415.00
08-27-09	XXXXX, MD (anesthesiologist)	\$244.00
09-28-09	XXXXX, MD (pain)	\$148.00
10-21-09	XXXXX, MD (neurosurgeon)	\$148.00

The Petitioner believes that these four visits were "presurgical" and therefore should be covered under the certificate's benefit for presurgical consultations. The August 19, 2009, visit was the first time she saw Dr. XXXXX – it was both a presurgical consultation and a second opinion. The August 27, 2009, visit was to determine the target area for her back problem and to target her later epidural injections. The September 28, 2009, visit was to review the results of the epidural

injections and to determine if back surgery was the best way to proceed. The October 21, 2009, visit was to review the epidural results.

The Petitioner argues that all of this care was medically necessary and should be covered as part of her care before surgery.

BCBSM's Argument

After review, BCBSM decided that the August 19, 2009, office consultation is a covered benefit and will pay its approved amount for this care.

However, BCBSM continues to deny the final three visits in dispute in this case because the claims were filed as office visits and the rider limits coverage to two physician office visits per calendar year. BCBSM says it is clear that this maximum had already been reached for 2009 before the Petitioner went to XXXXX.

BCBSM disputes the Petitioner's contention that the visits (other than the August 19, 2009, visit) were for presurgical services. The August 19, 2009, visit was billed as an office consultation (procedure code 99245) which may have been appropriately used as a presurgical consultation. However, with the subsequent visits, BCBSM was clearly billed for office visits; the rider places limits on the number of office visits and that limit was exceeded by the time the claims were filed.

BCBSM argues that it does not have the right to change the coding of the providers claims. Since the claims were filed as office visits and the maximum number of visits was exceeded they are not a covered benefit.

Commissioner's Review

The certificate covers surgical services. BCBSM considers the Petitioner's August 19, 2009, visit to Dr. LaMarca to be related to the surgery and it has agreed to pay for that visit.

The Petitioner is correct that presurgical consultations are covered. However, the presurgical consultation benefit is specifically defined in the certificate:

Presurgical Consultations

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon.

* * *

You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion -- a consultation to confirm the need for surgery
- Third opinion -- allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion -- given to determine your medical tolerance for the proposed surgery

A review of the visits leads to the conclusion that they were office visits, not presurgical consultations. The August 27, 2009, visit was with an anesthesiologist to discuss the Petitioner's epidural injection to treat her back pain. The procedure code filed with the claim by the physician was an office visit; the medical notes indicate it was not a presurgical consultation and was not done by a surgeon. The same was the case for the September 28, 2009, visit. It was with an anesthesiologist and was done to discuss the results of the latest epidural injection.

Finally, the October 21, 2009, visit was with the Petitioner's surgeon. He filed it as a physician office visit and not a consultation. Since BCBSM covered a presurgical consultation with the same doctor for the same condition on August 19, 2009, another presurgical consultation would not be a covered benefit. Also, the physician's notes reflect that the Petitioner had not decided to have the surgery at the end of the visit. Therefore, this visit would not be part of the payment for the surgery.

Finally, the Petitioner has only limited coverage for physician's office visits. The rider amends the certificate by adding the following to "Physician and Other Professional Provider Services That Are Payable" subsection:

Office Visits

We pay our approved amount for two office visits (whether they are medically necessary or not), per member, per calendar year, when performed by a panel provider.

By the time the Petitioner received services from XXXXX, she had already exceeded her two visit maximum for calendar year 2009 (she had office visits on January 4, January 15, January 29, July 31, and August 10, 2009).¹ Therefore, all three of the visits in dispute are not covered under the terms of the certificate and the rider.

The Commissioner finds that when BCBSM pays for the August 19, 2009, physician consultation it will have met its obligation under the Petitioner's contract and is not required to cover the August 27, 2009, September 28, 2009, and October 21, 2009, physician office visits.

V
ORDER

BCBSM's June 24, 2010, final adverse determination is reversed in part. Based on its August 18, 2010, letter to the Commissioner, BCBSM shall cover the Petitioner's August 19, 2009, office consultation. BCBSM is not required to cover the August 27, 2009, September 28, 2009, or October 21, 2009, physician office visits.

BCBSM shall provide coverage for the office consultation on August 19, 2009, 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 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. 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.

¹ BCBSM indicated that it had paid for a number of office visits before those in question here and some of those were paid

R. Kevin Clinton
Commissioner

in error BCBSM has agreed not to attempt to recoup those payments.