

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. 114715-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 2nd day of May 2011
by R. Kevin Clinton
Commissioner

ORDER

I

PROCEDURAL BACKGROUND

On October 12, 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 October 19, 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 October 28, 2010.

Because medical issues were involved, the Commissioner assigned the case to an independent review organization which provided its analysis and recommendation to the Commissioner on November 3, 2010.

The Petitioner is enrolled for health care through nongroup (individual) coverage that is underwritten by BCBSM. His benefits are defined in the BCBSM *Nongroup Comprehensive Health*

Care Benefit Certificate (the certificate).

II FACTUAL BACKGROUND

On November 2, 2009, the Petitioner had a bone graft placed and tooth #4 surgically extracted. The services were rendered by XXXXX, DDS. When the charge of \$875.00 was submitted, BCBSM denied coverage because the Petitioner's certificate does not cover dental services.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on September 29, 2010, and issued a final adverse determination dated October 6, 2010, upholding the denial.

III ISSUE

Is BCBSM required to cover the Petitioner's dental services?

IV ANALYSIS

Petitioner's Argument

The Petitioner's bone augmentation surgery was performed because of receding bone. He says if the surgery had not been done it "would cause big problems later." He believes the bone graft was for a medical, not dental, condition and should be covered by his medical insurance.

The Petitioner argues that the surgery was medically necessary and a covered benefit and BCBSM is required to pay for the procedure.

BCBSM's Argument

BCBSM says the Petitioner's medical coverage includes only very limited dental services. BCBSM cites the following provisions in the certificate (p. 3.3) under "Physician and Other Professional Provider Services That Are Payable":

Restrictions

- Dental surgery is payable **only** for:

- Multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition
- Surgery on the temporomandibular joint (jaw joint) dysfunction
- Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction

In addition, the certificate has these exclusions (p. 3.20):

The following services are not payable:

- Dental care (except as stated under surgery services)
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue

BCBSM says that under the terms of the certificate only limited dental care is covered. The only dental surgeries that are payable are multiple extractions, surgery on the jaw joint, and arthrocentesis for the treatment of jaw joint problems.

BCBSM does not dispute that the Petitioner's surgery was medically necessary but says his bone graft is not a benefit under his coverage.

Commissioner's Review

Initially, the Commissioner notes that there was no information provided to show that the Petitioner's dental services were provided while he was an inpatient in the hospital, or were to treat a jaw joint problem. Therefore, the Commissioner finds nothing in the dental surgery benefit that would provide coverage for Petitioner's bone graft, even if it was medically necessary. Medical necessity alone is not determinative of coverage -- the care must also be a benefit under the terms of the health plan. In the Petitioner's certificate, dental care is excluded from coverage.

The Petitioner's certificate covers medical services. Dental care is only covered in very limited circumstances. The Petitioner believes the procedure was medical, not dental, and should be covered.

The question of whether the surgery was a medical procedure or a dental procedure was presented to an independent review organization (IRO) for a recommendation as required by Section 11(6) of Patient's Right to Independent Review Act, MCL 550.1911. The IRO reviewer is a licensed dentist who has been in practice for more than fifteen years. The IRO dentist consultant determined that the bone augmentation procedure the Petitioner underwent on November 11, 2009, was dental in nature. The IRO report explained:

The MAXIMUS dentist consultant noted that the extraction of tooth #4 on 11/2/09 was necessitated by a vertical fracture. The MAXIMUS dentist consultant also noted that this extraction was apparently followed by placement of an implant, which was stabilized by the bone augmentation (grafting) procedure. The MAXIMUS dentist consultant explained that the bone augmentation procedure can only be considered to be dental in nature because it was performed solely to support an implant used after removal of a tooth. The MAXIMUS dentist consultant also explained that this was not a medical related dental procedure.

While the Commissioner is not required in all instances to accept the IRO's recommendation it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principle reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the conclusion of the IRO and finds the services the Petitioner received on November 11, 2009, were dental, not medical, services, and were therefore excluded from coverage.

The Commissioner concludes that BCBSM's denial is consistent with the terms of the certificate.

**V
ORDER**

BCBSM's final adverse determination of October 6, 2010, is upheld. BCBSM is not required to cover the Petitioner's dental services.

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.

R. Kevin Clinton
Commissioner