

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

In the matter of

XXXXX

Petitioner

File No. 118155-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 19th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On November 19, 2010, XXXXX, authorized representative of 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 (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the material submitted and accepted the request on November 30, 2010.

The Commissioner immediately notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review request and asked for the information it used to make its adverse determination. The Commissioner received BCBSM's response on November 29, 2010.

This case does not involve issues of medical necessity or clinical review criteria; it involves purely contractual provisions of the Petitioner's benefit plan and can be decided by a contractual analysis. The contract here is BCBSM's *Group Conversion Comprehensive Health Care Benefit Certificate* (the 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

On July 6, 2009, the Petitioner had bariatric surgery. BCBSM subsequently denied coverage for the surgery on the basis that it was not a benefit under the certificate. The Petitioner appealed BCBSM's decision. BCBSM held a managerial-level conference on September 15, 2010, and issued a final adverse determination dated September 20, 2010, upholding the denial.

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's bariatric surgery?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states that BCBSM advised her that bariatric surgery was a covered benefit under the certificate and that she was "nonplussed" when she learned that claims for anesthesia, the surgeon, and the hospital were denied. She believes she was misinformed about the benefit and wants BCBSM to cover the claim for the surgery.

BCBSM's Argument

In its November 19, 2010, final adverse determination, BCBSM stated:

[The Petitioner] is enrolled under our *Group Conversion Comprehensive Health Care Benefit Certificate*. Page 2.19 of that certificate indicates that we do not pay for hospital admissions for "weight reduction." As a result, our denial of payment for the admission and related professional charges is correct.

BCBSM also refuted the Petitioner's contention that it told her the bariatric surgery was a covered benefit:

With regard to the telephone call you mentioned during the [managerial-level] conference, we have no record of a May 14, 2009 call from . . . the provider's office. We do have a record of a May 15, 2009 call made by . . . the provider's office and one from [the Petitioner's husband] on April 27, 2009. Neither call was recorded. . . .

As you will see, [the Petitioner's husband] specifically asked about several procedure codes and was informed that gastric bypass surgery is not a benefit. The other call gives one procedure code (43770) for the gastric bypass surgery, but the notes do not confirm that the provider was told it is payable. Additionally, the doctor did not even bill 43770. Rather he billed

code 43644 (laparoscopy, surgical, gastric restrictive procedure). At no time, was that procedure approved during a telephone conversation. Therefore, the charges remain [the Petitioner's] liability.

In a letter dated December 9, 2010 to the Office of Financial and Insurance Regulation, BCBSM acknowledged that it had given out incorrect information about the bariatric surgery benefit to other subscribers around the time the Petitioner had her surgery but denied that its error had any affect in this case:

. . . While we have no record of the provider's office being told by anyone at BCBSM that bariatric surgery was a payable benefit, we must acknowledge, that during this approximate period BCBSM was incorrectly informing members this procedure was payable. As such, BCBSM developed a corporate policy which took the position that if BCBSM incorrectly told the member the surgery was payable, and the surgery was completed by June 1, 2009, BCBSM would pay the claims. However, that does not appear to be the case here.

The incorrect information was corrected in April 2009 about the time that [the Petitioner's husband] was in contact with BCBSM. Additionally, by May 2009, corrected information was being provided to the members and providers.

BCBSM argues that its denial of the claims for the Petitioner's bariatric surgery was appropriate under the terms of the certificate.

Commissioner's Review

A

The Commissioner first decides if bariatric surgery is a covered benefit for the Petitioner. The certificate contains this provision in "Section 2: Coverage for Hospital, Facility, and Alternatives to Hospital Care" (pp. 2.18 – 2.19):

Hospital admissions that are not covered by your certificate include:

* * *

- Those for care that is not considered acute, such as:

* * *

- Weight reduction

There is nothing in the record that would lead to a finding that the Petitioner's bariatric surgery on July 6, 2009, was as the result of an acute condition. Therefore, the Commissioner

concludes that weight reduction surgery is not a covered benefit and that BCBSM was correct in its decision to deny the Petitioner's claims on that basis.

B

Although she provided no specifics, the Petitioner's entire case rests on her assertion that she was misinformed by BCBSM about the benefit for bariatric surgery and, presumably, acted in reliance on that misinformation. BCBSM denies the Petitioner's allegation and offers a different version of the facts.

Unfortunately, it is not possible for the Commissioner to resolve this dispute. The Patient's Right to Independent Review Act (PRIRA) provides only a "paper" hearing. See *English v Blue Cross Blue Shield of Michigan*, 263 Mich App 449 (2004). The PRIRA process does not afford the Commissioner the opportunity to make the kind of fact finding that would be needed to support or refute the Petitioner's contention. Moreover, the Commissioner lacks the authority, which the circuit courts possess, to base a decision on such doctrines as reliance or estoppel. Under PRIRA, the Commissioner is limited to determining if a disputed health care service is required by the terms of the certificate or state law. In this case, the Commissioner finds that the Petitioner's bariatric surgery is not a covered benefit.

V. ORDER

BCBSM's November 19, 2010, final adverse determination is upheld. BCBSM is not required to cover the Petitioner's bariatric surgery.

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 60 days from the date of this Order in the circuit court for the county where the covered person resides or 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