

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

Comprehensive Home Health Care, Inc.
Petitioner

Docket No. 11-000793-OFIR
Case No. 11-834-BC

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 18th day of September 2013
by **R. Kevin Clinton**
Director

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan (BCBSM) of one of its participating providers, Comprehensive Home Health Care, Inc. (Comprehensive). Two events prompted the audit: Comprehensive's claims filed with BCBSM jumped from \$27,000 in 2005 to \$211,000 in 2006 and, in April 2008, BCBSM received an anonymous complaint on its anti-fraud web site asserting that Comprehensive was billing BCBSM for claims already paid by Medicare.

In the audit, BCBSM examined billings Comprehensive submitted to BCBSM for certain home health care services between August 2006 and April 2008. Based on its audit findings, BCBSM concluded that Comprehensive had improperly billed BCBSM for services which were not benefits payable under the BCBSM policies which provided health care coverage to Comprehensive's customers. Consequently, BCBSM sought recovery of \$527,547.36 from Comprehensive.

When the dispute was not resolved by the parties informally, a Review and Determination proceeding was held by the Director's designee.¹ The proceeding addressed the results of BCBSM's audit and Comprehensive's allegation that BCBSM had violated provisions of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), BCBSM's governing statute, by misrepresenting coverage provisions and failing to promptly settle claims where BCBSM's liability had become clear.

1. See MCL 550.1404.

The report of the Director's designee was issued May 17, 2011. The Director's designee concluded that BCBSM had not violated Act 350 and should be permitted to pursue recovery of the disputed claim payments.

The Review and Determination conclusions were appealed to the Director by Comprehensive. A contested case hearing was held on January 8, 2013. The administrative law judge issued a Proposal for Decision (PFD) on June 7, 2013. In the PFD, the administrative law judge accepted the analysis of the Director's designee and recommended that the Director make the following findings:

- BCBSM did not violate section 402(1)(f) of Act 350, and
- BCBSM should be permitted to recover a refund of \$527,547.36 from Comprehensive Home Health Care, Inc.

The Petitioner filed exceptions to the PFD on June 26, 2013. After examination of the hearing record and review of the PFD, the Director makes the following findings and conclusions.

II. FINDINGS OF FACT

There is one correction to be made in the PFD's Findings of Fact. On page 9, Finding of Fact paragraph #10, line 3: "Respondent" is changed to "Petitioner."

With the correction noted above, the Findings of Fact in the PFD are supported by the hearing record. The Director adopts and incorporates the Findings of Fact as part of this order. The PFD is attached.

III. CONCLUSIONS OF LAW

There is one correction to be made in the PFD's Conclusions of Law. On page 12, paragraph 2, line 13: "Petitioner" is changed to "Respondent." With the correction noted above, the Director finds that the Conclusions of Law stated in the PFD are properly grounded in the facts of this case and are soundly reasoned. Those findings are adopted:

- BCBSM did not violate any provision of Act 350 when it pursued a refund based on its audit of Petitioner.
- The \$527,547.36 BCBSM seeks to recover is comprised of two categories of payment: \$421,406.78 for copayments by Medicare primary patients where the

BCBSM supplemental insurance benefit did not allow for secondary copayments and \$106,140.58 for services for which the Petitioner failed to follow mandatory Medicare “demand billing” procedure.

The Director makes the following additional conclusion of law:

- Petitioner’s assertion that BCBSM had not paid \$260,000.00 in outstanding claims has not yet been appealed to BCBSM and is, therefore, not appropriate to be considered as an issue in the present case.

IV. PETITIONER’S EXCEPTIONS

In its exceptions, the Petitioner presented six arguments which are addressed below.

1. Petitioner’s October 2008 Claims

The Petitioner argues that BCBSM’s failure to issue denials for \$260,000.00 in outstanding claims is a “per se violation of Section 402(1)(b), (e), and (l) of Act 350.” The BCBSM audit, which is the subject of the hearing and PFD, covers the period between August 2006 and April 2008. The \$260,000.00 in claims referenced in this exception did not occur during the audit period and were not part of the audit. These claims were noted only briefly in the Review and Determination and were not among the conclusions stated in the Review and Determination. The PFD correctly states that consideration of these claims is not appropriate in the context of this appeal.

2. BCBSM Billing Instructions

The Petitioner argues that there was no evidence presented that anyone other than the BCBSM “consultants” showed the Petitioner’s billing employee, Sheryl Krey, how to bill BCBSM for the claims at issue. (It is not clear in the record just what function the “consultants” served for BCBSM or the scope of their authority as BCBSM representatives.)

The Petitioner argues that, once it presented evidence of such instruction, it was BCBSM’s obligation to present evidence rebutting the Petitioner’s evidence. The Director notes that neither the consultants nor Ms. Krey testified at the hearing. The Petitioner’s witness, Mahmoud Aldwake, testified that he was not present during those meetings and therefore had no direct evidence of any instructions from BCBSM consultants.

An affidavit from Ms. Krey was a hearing exhibit. (Exhibit #9.) The PFD described Ms. Krey’s affidavit and concluded that she may have misunderstood the difference between

“secondary insurance” and “supplemental insurance.” Ms. Krey’s affidavit indicates only that a BCBSM agent/consultant met with Petitioner’s billing staff person and showed her how to bill the services in question. Regarding specific billing practices, Ms. Krey states that she checked each individual’s policy to confirm the individual had coverage for home health care services. Ms. Krey further stated that Comprehensive never billed for those services where the individual’s policy did not have that coverage. This is not evidence that the Petitioner’s billing practices were correct in an objective sense or even proof that Petitioner billed in the manner the consultant may have prescribed. In contrast to Ms. Krey’s affidavit, there is a significant volume of evidence from BCBSM showing that the Petitioner did not use correct BCBSM billing procedures. See PFD Findings of Fact #7 - #23.

3. The PFD Created an Improper Theory of the Case

The Petitioner asserted that the PFD, without evidence, concluded that “another consultant, not employed by [BCBSM], advised him that he could bill [BCBSM] in this way.” This is a portion of the PFD’s Finding of Fact # 33. In its complete form Finding of Fact # 33 states:

Respondent’s consultants did not likely instruct Petitioner’s billers to submit bills for non-covered services, contrary to Petitioner’s contention. Respondent’s investigator likely learned from Mr. Mahmoud that another consultant, not employed by Respondent, advised him that he could bill Respondent this way. The investigation report credibly reflects the following, “According to Aldwake, a friend of his was billing additional payments to BCBSM and was eventually told by BCBSM to stop the billings; however, he did not have to pay this money back.” [Pet. Exh. 8].

When Finding of Fact #33 is read in its entirety, two things become clear: 1) the PFD did not “conclude” a theory of the case for which there was no evidence, and 2) the PFD did not speculate, in the absence of evidence, that another consultant was the source of information on how to bill BCBSM. Finding of Fact #33 is not “a theory of BCBSM’s case which BCBSM never asserted,” as the Petitioner claims. This particular finding is taken from a BCBSM document (Exhibit #8, page 2 of the BCBSM investigation report). This document was not challenged by the Petitioner during the hearing. Mr. Aldwake was a witness at the hearing and could have been questioned about the investigation report which quoted him.

4. "Demand Billing"

The Petitioner argues that the PFD erroneously concluded that the Petitioner was required to use Medicare's "demand billing" procedure to obtain a claims denial before the claim could be submitted to BCBSM. The Petitioner provides no citation to the PFD where this conclusion is stated. Finding of Fact #22 does state that the Petitioner could have used the Medicare demand billing procedure but the PFD does not conclude that there was a requirement to do so.

5. Co-Payment Requirements

The Petitioner argues that a conclusion in the PFD that "supplemental benefits allowed for payment of copayments only" was a conclusion which is not based on any material in the record. In fact, there is no mention of copayment in the PFD's conclusions of law. Copayments are mentioned in two findings of fact (#10 and #28) and are sourced to documents in the record.

6. Detrimental Reliance

The Petitioner's final exception is that "[t]he conclusion in the PFD that Petitioner did not establish that it reasonably relied on BCBSM's alleged payment of the claims in error" is contrary to the evidence presented at hearing. Petitioner argues that it did establish that it relied, to its detriment, on BCBSM's claims payments and that such detrimental reliance is sufficient reason to prohibit BCBSM from collecting its erroneous payments. The Petitioner cites a prior decision by this department in a BCBSM audit appeal, *Internal Medicine Associates of Mt. Clemens v BCBSM* (2011), as establishing the rule that detrimental reliance is a defense against audit-based BCBSM refund demands. The Petitioner has oversimplified the holding in the *Internal Medicine Associates*. In that case, the Director found that the provider being audited had relied on BCBSM's own published description of allowable claims. In the present case, the Petitioner is relying on its own version of information its owner says his employees were given by BCBSM consultants. The Director agrees with the PFD that this evidence is too tenuous to serve as a basis for excusing the Petitioner from refunding improper payments it received.

V. ORDER

It is ordered that BCBSM may recover \$527,547.36 from Comprehensive Home Health Care, Inc.



R. Kevin Clinton
Director

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:

Docket No.: 11-000793-OFIR

Comprehensive Home Health Care, Inc.,
Petitioner

Case No.: 11-834-BC

v

Agency: Department of Insurance
and Financial Services

Blue Cross Blue Shield of Michigan,
Respondent

Case Type: DIFS-Insurance

Filing Type: Appeal
Subscriber/Provider

Issued and entered
this 7th day of June 2013
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

Appearances: Keith J. Soltis, Attorney at Law, appeared on behalf of Comprehensive Home Health Care, Inc., Petitioner. Bryant D. Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Respondent.

This proceeding under the Nonprofit Health Care Corporation Act, 1980 PA 350, as amended, MCL 550.1101 *et seq.* (hereafter "Nonprofit Act") commenced in the Michigan Administrative Hearing System with the issuance of a Notice of Hearing on August 5, 2011, which scheduled a contested case hearing for September 7, 2011. The Notice of Hearing was issued pursuant to a July 22, 2011 request for hearing and Order Referring Complaint for Hearing and Order to Respond by Randall S. Gregg, Special Deputy Commissioner, dated July 21, 2011.

The Complaint references allegations set forth in the Petitioner's Request for Contested Case Hearing, dated July 12, 2011, by which Petitioners seek reversal of the Review and Determination issued by the Commissioner's Designee on May 17, 2011. The Commissioner's Designee concluded that Respondent had not violated any of the provisions of Section 402 of the Nonprofit Act when it pursued a refund request from Petitioner and denied payment on additional claims.

On August 10, 2011, the undersigned issued an Order Granting Adjournment, by which the September 7, 2011 hearing date was adjourned and rescheduled to October 6, 2011. On August 25, 2011, the undersigned issued an Order Granting Adjournment and Scheduling Telephone Prehearing Conference. On August 30, 2011, Respondent filed its Answer to Petitioner's Request for Contested Case Hearing.

On October 6, 2011, a telephone prehearing conference was held as scheduled. On October 13, 2011, the undersigned issued an Order Following Prehearing Conference.

On November 7, 2011, Petitioner filed its Initial Discovery Requests from Blue Cross Blue Shield of Michigan. On November 17, 2011, Petitioner filed its Witness and Exhibit Lists.

On December 5, 2011, Petitioner filed a Motion for Summary Judgment. On December 5, 2011, Petitioner filed a request to convert the December 13, 2011 hearing date to a telephonic motion hearing. On December 6, 2011, the undersigned issued an Order Granting Adjournment and Scheduling Telephone Motion Hearing. On December 7, 2011, Petitioner filed a Correction to Motion for Summary Judgment. On December 12, 2011, Respondent filed its Opposition to Petitioner's Motion for Summary Judgment.

On December 13, 2011, a motion hearing was held by telephone as scheduled. On December 16, 2011, the undersigned issued an Order Denying Petitioner's Motion for Summary Judgment, which scheduled hearing for February 28, 2012. On February 8, 2012, Petitioner filed a stipulation of the parties to adjourn the hearing. On February 27, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to May 30, 2012.

On May 2, 2012, Petitioner filed an Amended Witness List. On May 8, 2012, Petitioner filed a Second Amended Witness List. On May 22, 2012, a witness subpoena was issued at Petitioner's request. On May 29, 2012, Respondent filed a stipulation of the parties to adjourn the hearing. On June 1, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to July 18, 2012. On June 27, 2012, a witness subpoena was issued at Petitioner's request. On July 16, 2012, Respondent requested an adjournment of the hearing. On July 18, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to September 27, 2012.

On August 30, 2012, Respondent filed a revised Witness List. On September 20, 2012, Petitioner filed an Amended Exhibit List. On September 25, 2012, Respondent filed stipulation of the parties to adjourn the hearing. On September 26, 2012, Petitioner submitted correspondence regarding rescheduling the hearing. On October 8, 2012, Respondent submitted correspondence regarding rescheduling the hearing. On October 31, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to December 18, 2012. On November 21, 2012, Petitioner filed a request for adjournment. On November 28, 2012, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to January 28, 2013.

On January 25, 2013, Petitioner filed its Second Amended Exhibit List and Third Amended Witness List. On January 25, 2013, Respondent filed its second revised Witness and Exhibit Lists.

On January 28, 2013, the hearing was held as scheduled. Petitioner called Mahmoud Aldwake, Owner and President of Comprehensive Home Health Care, Inc., to testify as a witness at the hearing. The following exhibits were offered by Petitioner and admitted into the record as evidence:

1. Petitioner's Exhibit No. 1 is a copy of Web-DENIS Benefit descriptions.
2. Petitioner's Exhibit No. 2 is a copy of handouts from Pam Rechul of Blue Cross Blue Shield of Michigan on how to bill.
3. Petitioner's Exhibit No. 3 is a copy of selected portions of Medicare Secondary Payer (MSP) Manual.
4. Petitioner's Exhibit No. 4 is a copy of Petitioner's documentation regarding non-paid claims.
5. Petitioner's Exhibit No. 5 is an excerpt from Respondent's Provider Manual.
6. Petitioner's Exhibit No. 6 is a copy of Respondent's letter to Petitioner, dated July 15, 2008.
7. Petitioner's Exhibit No. 7 is a copy of miscellaneous correspondence between Petitioner, its agents and employees, and Respondent.
8. Petitioner's Exhibit No. 8 is a copy of selected portions of Respondent's audit file.
9. Petitioner's Exhibit No. 9 is a copy of an affidavit of Sheryl Krey, dated May 23, 2012.
10. Petitioner's Exhibit No. 10 is a copy of selected portions of the Medicare Claims Processing Manual, Chapter 10 – Home Health Agency Billing.
11. Petitioner's Exhibit No. 11 is a copy of affidavits of Wanda Lee, dated July 14, 2012 and October 4, 2012.

Respondent called Steven Ryner, Blue Cross Blue Shield of Michigan investigator, and Constance Blachut, Manager of Professional Utilization Review for Blue Cross Blue Shield of Michigan, to testify as witnesses at the hearing. The following exhibits were offered by Respondent and admitted into the record as evidence:

1. Respondent's Exhibit No. 1 is a copy of an Affidavit of Mahmoud Aldwake, dated December 2, 2011.

2. Respondent's Exhibit No. 2 is a copy of a letter from Respondent to Petitioner, dated July 15, 2008, with requested refund spreadsheet.
3. Respondent's Exhibit No. 3 is a copy of selected sections of Medicare Benefit Policy Manual, Chapters 7 & 10.
4. Respondent's Exhibit No. 4 is a copy of a business card of Pam Rechul, former Provider Consultant, Blue Cross Blue Shield of Michigan.
5. Respondent's Exhibit No. 5 is a copy of a business card of Valerie Rose, former Provider Consultant, Blue Cross Blue Shield of Michigan.
6. Respondent's Exhibit No. 6 is a copy of the Participation Agreements between Petitioner and Respondent, dated October 21, 2008, and July 25, 2005, with attachments.
7. Respondent's Exhibit No. 7 is a copy of a letter to Keith J. Soltis, Attorney for Petitioner, from Connie Blachut, Manager, Professional Utilization Review (Respondent), dated November 5, 2008.
8. Respondent's Exhibit No. 8 is a copy of Review and Determination by Susan M. Scarane, Commissioner's Designee, dated May 17, 2011.

At the conclusion of the hearing, the record was held open for the submission of written closing arguments. On February 22, 2013, Petitioner filed a copy of the transcript of the January 28, 2013 hearing (hereafter "Tr"). On March 6 2013, the undersigned issued an Order Scheduling Written Closing Arguments.

On March 22, 2013, Petitioner filed its Closing Brief. On March 22, 2013, Respondent filed its Closing Argument. On April 4, 2013, Petitioner filed its Rebuttal Brief. On April 8, 2013, Respondent filed its Rebuttal Brief and the record was then closed.

ISSUES AND APPLICABLE LAW

The central issues presented in this matter are:

1) Whether Respondent has violated Sections 402(1)(a)-(f) & (l)-(m) of the Nonprofit Act, *supra*, as alleged in the Complaint and Petitioners' Request for Contested Case Hearing; and

2) Whether Respondent is entitled to seek refund from Petitioner, totaling \$527,547.36, following post-payment audit, and/or required to pay additional claims.

The applicable statutory sections of the Nonprofit Act provide as follows:

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

* * *

(l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate. MCL 550.1402(1)(a-f) & (l-m).

Petitioner requested a contested case hearing in accordance with Section 404(6) of the Nonprofit Act, *supra*, which provides:

Sec. 404. (6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act. MCL 550.1404(6).

The administrative rules on Procedures for Informal Managerial-Level Conferences and Review by Commissioner of Insurance, 1986 AACS, R 550.101 *et seq.*, state in pertinent part:

Rule 102. (1) A person who believes that a health care corporation has wrongfully refused his or her claim in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, or has otherwise violated section 402 or sections 403 of Act No. 350 of the Public Acts of 1980, as amended, shall be entitled to a private informal managerial-level conference with the health care corporation.

* * *

(4) At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws. 1986 AACS, R550.102(1)&(4).

Rule 103. (1) Within 10 days of the conclusion of the private informal managerial-level conference, the health care corporation shall provide all of the following information to the grievant:

- (a) The proposed resolution of the health care corporation.
- (b) The facts, with supporting documentation, upon which the proposed resolution is based.
- (c) The specific section or sections of the law, certificate, contract, or other written policy or document upon which the proposed resolution is based.
- (d) A statement explaining the person's right to appeal the matter to the commissioner within 120 days after receipt of the health care corporation's written statement provided in subrule (2) of this rule.
- (e) A statement describing the status of the claim involved. 1986 AACS, R 550.103(1).

Rule 104. (2) The grievant may appeal to the commissioner within 120 days of the date the person received the health care corporations' proposed resolution . . . 1986 AACRS, R 550.104(2):

Rule 105. (3) The commissioner or commissioner's designee shall conduct meetings in a manner which allows the disputing parties to present relevant information to substantiate their positions. 1986 AACRS, R 559.105(3). (Emphasis supplied).

Rule 107.(3) The commissioner or the commissioner's designee shall notify the health care corporation and the grievant of the right to request a contested case hearing if a party disagrees with the written decision. 1986 AACRS, R 550.107(3). (Emphasis supplied).

Rule 108. (1) If the decision by the commissioner or the commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.

(2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of the claim. 1986 AACRS, R 550.108.

FINDINGS OF FACT

Based on the entire record in this matter, including the witness testimony and admitted exhibits, the following findings of fact are established:

1. Petitioner is a home health care company with its principal place of business in Dearborn, Michigan. Mahmoud Aldwake is the company's owner and President/CEO. [Tr, pp 23-24].
2. Effective June 3, 2005, Petitioner entered into a Participation Agreement with Respondent, which governed the terms of claims payment at times relevant to this matter. [Resp. Exh. 6].

3. Between August 2006 and April 2008, Petitioner submitted claims to Respondent for reimbursement of certain services. According to Petitioner, it billed Respondent for additional services of physical therapy, skilled nursing, medical social services, and home health care aides. [Pet. Exh. 8].
4. Petitioner contends that in or around September 2005, it was called by a regarding her husband receiving home health aide services for five hours a day, five days a week, which was more time than Medicare would cover. According to Petitioner, had a rider on her insurance policy with Respondent that would cover additional home health services above and beyond what Medicare would cover. Petitioner contends that indicated that she had contacted Respondent and been told that these additional home health services should be covered under her policy. [Tr, p 25].
5. Petitioner contends that it next contacted Respondent and was informed that the additional home health services were covered on the patient's supplemental insurance policy with Respondent. [Tr, pp 25-26].
6. According to Petitioner, Respondent gave Petitioner the names of two consultants, Pam Rechul and Valerie Rose, to help with submitting bills for the additional services. Petitioner contends that Ms. Rechul and Ms. Rose came to Petitioner's offices and showed its billing personnel how to submit claims for such additional services. [Tr, pp 26-27; Pet. Exh. 2].
7. The record contains an affidavit from Sheryl Krey, Petitioner's billing employee at times relevant, stating that "Ms. Rechul and Ms. Rose spent several hours with me and the other billing personnel advising us on the procedure for submitting claims to BCBSM [Respondent] as a secondary insurer to Medicare for the home health care services in question, including which billing codes should be utilized for this purpose." [Pet. Exh. 9].
8. In her affidavit, Sheryl Krey states that prior to providing services and submitting claims for home health care services, Petitioner "verified the coverage of individual subscribers/beneficiaries for the services by looking up the individual's coverage using BCBSM's 'Web-DENIS' internet feature and identifying whether each subscriber/beneficiary had coverage for home health services. This procedure included a review of the patient's policy certificate as not all BCBSM policies covered such service." [Pet. Exh. 9].
9. Petitioner's billing personnel may have misconstrued the meaning of secondary insurance in the context of coordination of benefits with supplemental insurance coverage. The record contains a handwritten statement, apparently from Pam Rechul, stating, "Met with Sheryl January 2006 and showed her how to bill BCBSM as a secondary insurance to Medicare." [Pet. Exh. 2, 4 & 9]. (Emphasis supplied).

10. The terms of individual patients' supplemental insurance policies likely varies. Some policies may cover Medicare co-payments and specific types of home health care services, while other policies do not. Respondent likely submitted claims to Respondent for payment of Medicare co-payments even where the supplemental insurance policies did not cover such co-payments. [Pet. Exh. 2; Resp. Exh. 3B].
11. In March 2008, Respondent's internal review showed that Petitioner's claims to Respondent went from \$27,610 in 2005 to \$211,481.00 in 2006. The record contains a copy of e-mails by Respondent's staff questioning this increase in billings. [Pet. Exh. 8].
12. On April 8, 2008, Respondent reportedly received an anonymous complaint on its online anti-fraud website concerning Petitioner. The complainant, who identified as working for another agency, asserted that Petitioner was billing Respondent for additional payment after having already received 100% payment from Medicare. [Pet. Exh. 8; Tr, p 57].
13. In July 2008, Respondent conducted a post-payment desk audit of Petitioner's claims for the period of January 1, 2006 through June 30, 2008. [Pet. Exh. 8].
14. Respondent determined that the payments at issue concerned individuals who were Medicare primary subscribers and Blue Cross Blue Shield of Michigan (Respondent) supplemental subscribers. [Tr, p 57].
15. The dollar amounts of the claims that were paid were identified as being for services that Medicare pays at 100%, but Respondent was billed for amounts over and above the Medicare payment amount. [Tr, pp 57, 59].
16. Petitioner likely based the claims in part upon services rendered by home health aides for non-skilled care, which Mr. Mahmoud testified was "basically to provide feeding, bathing, dressing, doing laundry, doing dishes, cleaning the patient's area, watching the patient and stuff like that." [Tr, p 48].
17. Petitioner contends that it was told by Respondent's representatives that Respondent would pay for non-covered Medicare services. Respondent's internal investigation report of July 21, 2008, reflects the view of Respondent's manager, Rose Zidzik, that the now retired Pam Rechul, "knew this was not a billable service and felt adamant that she would not have told CHHC [Petitioner] to bill this way." [Pet. Exh. 8].
18. Petitioner likely made an initial general inquiry of Medicare regarding the types of home health services that were covered. Mr. Aldwake testified that "Medicare said that they cannot do these types of things like, 'I deny this and' – they don't do these types of things. Their system does not allow that, so you bill them.

They pay their portion and you are free to bill other carriers if you can." [Tr, p 36].

19. In submitting claims to Respondent for home health care services under patients' supplemental policies, Petitioner did not likely follow Medicare's established process for "demand billing" set forth in the Medicare Benefit Policy Manual by first obtaining individual denials from Medicare before billing Respondent. [Tr, pp 36, 52-59; Resp. Exh. 3].
20. Petitioner apparently simply relied upon language in patients' supplemental subscriber policies that indicated home health services "will be covered at 100 percent". Petitioner apparently took "100 percent" to mean that Respondent would cover all non-skilled home health care services in addition to skilled care. Petitioner had reason to know, however, that the coverage in patients' supplemental policies differed and that it was required to follow the "demand billing" process. [Tr, p 50; Pet. Exh. 1].
21. It is likely that Medicare has criteria for the reimbursement of home health care services in certain types of activities of daily living (ADLs), such as assisting with bathing. It is likely that certain criteria pertains to reimbursement of such services, including that it be a service ordered by a physician and that it needed to be performed by a home health aide because the patient was unable to do the ADL or a family member was not able to help. [Tr, p 98].
22. If Petitioner had submitted the claims to Medicare as the primary insurer under the "demand billing" process and received denials, Respondent could have then made a determination as to whether the services were properly paid under the individual patients' policies as supplemental to Medicare. [Resp. Exh. 3C; Tr, p 59].
23. Respondent did not have an edit in its system to prevent paying for the claimed services and apparently paid the services to Petitioner in error during the time period in question. Respondent's internal investigation showed that its "facility services did not read the home health care covered service documentation correctly and claims were paid." [Tr, pp 64-66; Pet. Exh. 8].
24. Per the terms of the Participation Agreement, Respondent can request a refund for payments made in error. [Tr, pp 66-68; Resp. Exh. 6].
25. On July 8, 2008, Michele Jakubiec, Field Investigator for Respondent, met with Mr. Mahmoud and Petitioner's billers regarding why Petitioner was billing Respondent for services that reportedly were already paid at 100% by Medicare.
26. On July 15, 2008, Ms. Jakubiec for Respondent sent a letter to Mr. Mahmoud for Petitioner regarding the audit findings and requested a refund of \$527,547.36. Respondent's letter stated that "[s]ince you were reimbursed 100% from

Medicare we must ask for \$527,547.36, which is the amount you submitted over Medicare's 100% reimbursement." A spreadsheet detailing the refund request was also included. [Pet. Exh. 6 & 8; Resp. Exh. 2].

27. Respondent's refund request letter of July 15, 2008 did not specifically advise Petitioner of its right to a managerial-level conference and appeal, but provided a contact telephone number for any questions. [Pet. Exh. 6; Resp. Exh. 2].
28. The record shows that \$421,406.78 of the total \$527,547.36 refund amount likely pertains to payments made by Respondent for copayments by Medicare primary patients, where the supplemental insurance benefit did not allow for secondary copayment. The balance of the \$527,547.36 amount likely pertains to services for which Petitioner did not follow the established "demand billing" process with Medicare. [Pet. Exh. 1, 6 & 8].
29. Where the supplemental insurance benefit did allow for secondary copayment, refund was not likely requested, as is shown in a comparison of Petitioner's Exhibit Nos. 1 and 6.
30. On July 21, 2008, Ms. Jakubiec prepared an investigative report for Respondent and concluded in part that Respondent "was reimbursing the services in error. . . . Facility Services did not read the Home Health Care covered service documentation correctly and claims were paid." [Pet. Exh. 8].
31. Petitioner requested reconsideration of the refund request, but the refund amount was not reduced. [Resp. Exh. 8].
32. In or around October 2008, a managerial-level conference was held between Petitioner and Respondent, after which Respondent maintained its refund request for \$527,547.36. [Resp. Exh. 8].
33. Respondent's consultants did not likely instruct Petitioner's billers to submit bills for non-covered services, contrary to Petitioner's contention. Respondent's investigator likely learned from Mr. Mahmoud that another consultant, not employed by Respondent, advised him that he could bill Respondent this way. The investigation report credibly reflects the following, "According to Aldwake, a friend of his was billing additional payments to BCBSM and was eventually told by BCBSM to stop the billings; however, he did not have to pay this money back." [Pet. Exh. 8].
34. Petitioner has not shown that it reasonably relied on the claims at issue having been correctly paid by Respondent and not being subject to a refund request.
35. Petitioner also contends that Respondent has not paid it for additional claims that were outstanding at the time of the refund request. Petitioner asserts that these additional claims amount to \$260,000.00, but it has not yet received denials from

Respondent or followed the administrative appeals process for these claims. There is some indication in Ms. Blachut's testimony that these additional claims were part of the parties' negotiation. [Pet. Exh. 4; Tr, p 82].

CONCLUSIONS OF LAW

Petitioner, as the complaining party, has the initial burden of proof in this matter to show by a preponderance of the evidence that Respondent has violated the Nonprofit Act, *supra*, as alleged in the Complaint and Request for Contested Case Hearing, and that Respondent is not entitled to the amount claimed as overpayment as a result of the post-payment audit. See, *Triad Diagnostics et al v Blue Cross Blue Shield of Michigan*, Case No. 11-837-BC, Docket No. 11-000814-OFIR (January 8, 2013), and Rules 3 and 27(2); 1983 AACS, R 500.2103 and R 500.2127(2).

Based on the above findings of fact, it is concluded that Petitioner has not met its burden of proof. The record evidence does not show that Respondent likely misrepresented pertinent facts or certificate provisions; failed to acknowledge promptly or act reasonably upon communications with respect to a claim; failed to adopt and implement reasonable standards for the prompt investigation of a claim; refused to pay claims without conducting a reasonable investigation based upon available information; failed to affirm or deny coverage of a claim within a reasonable time after a claim had been received; failed to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability had become reasonably clear; failed to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement; or failed to promptly settle a claim where liability had become reasonably clear. Therefore, Petitioner has not proven by a preponderance of evidence that Petitioner violated Section 402(1)(a)-(f) & (l)-(m) of the Nonprofit Act when it pursued a refund request from Petitioner in the amount of \$527,547.36.

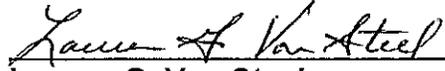
Further, as indicated above, Petitioner contends that Respondent has failed to pay outstanding claims amounting to \$260,000.00. However, Petitioner has not yet appealed the denial of these claims as contemplated by the administrative rules in 1986 AACS, R 550.101 *et seq.* As such, the additional claims are not properly considered in this appeal.

PROPOSED DECISION

Based on the above findings of fact and conclusions of law, the undersigned Administrative Law Judge proposes that the Department Director issue a Final Order that finds no violation of the Nonprofit Act by Respondent as alleged, and that affirms the Review and Determination finding that Respondent is entitled to seek a refund from Petitioner in the amount of \$527,547.36.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Office of Financial and Insurance Regulation, Division of Insurance, Attention: Dawn Kobus, P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after exceptions are filed.



Lauren G. Van Steel
Administrative Law Judge