

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

In the matter of:

██████████
Petitioner

v

File No. 145354-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 2nd day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 11, 2014, ██████████, authorized representative of her son ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on December 18, 2014.

The Petitioner receives dental care benefits through an individual plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM's response was received on December 23, 2014.

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

The Petitioner went to the dentist on July 23, August 11, and August 13, 2014. The amount charged for this care was \$445.00. BCBSM denied coverage for those services because the dentist was not part of the preferred network.

The Petitioner appealed BCBSM's denial through its internal grievance process. At the conclusion of that process BCBSM issued a final adverse determination dated November 17, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's dental care provided by a nonpreferred network dentist?

IV. ANALYSIS

BCBSM's Argument

In its final determination, BCBSM explained to the Petitioner its reason for denying his dental care:

Your request for reconsideration of the previous benefits provided for this service has been denied. The policy selected, the Blue Dental EPO Personal Policy, specifies that members must choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network. If you visit a dentist who is non-network, you are responsible for all costs for services rendered.

Please be advised that a "Participating Provider" is simply a dentist choosing to participate on a claim-by-claim basis. When a dentist participates, we send payment directly to their office. Dentists who belong to the DNoA Preferred Network are contracted and participate on all claims and agree to accept the contracted fee scheduled specific to the network they have signed up with (Dentemax, DNoA, or Careington). This information is specified on page 7-8 in the latest edition of the BCBSM Dental Guide for Providers, which is distributed to all Michigan dentists.

It is also suggested to call and obtain benefits and eligibility prior to having any services rendered. Each policy can have terms, conditions and limitations that apply. A quote of benefits is not always a guarantee of payment. Our records do not indicate that any inquiries were made prior to services being rendered.

Petitioner's Argument

The Petitioner's mother made her argument in a September 20, 2014, that was included with his external review request. She wrote that her son's dental coverage with BCBSM began in January 2014 and he needed to choose a new dentist. They went to [REDACTED] in [REDACTED]

We presented his card and asked if they were participating with BCBS, to which we received the reply, yes. We then proceeded to make an appointment to have his yearly cleaning and check. [Petitioner] then attended his appointment and received a proposed treatment plan stating what he needed to have done, how much it would cost, and what the proposed insurance payment and co-pay....

[Petitioner] then set up his appointment for the work to be done and paid his \$60.00 co-pay....

Then we started receiving bills stating we went to a non-participating dentist. So I made calls to the dentist, they had no idea as to why the bills were not covered.

The Petitioner's mother indicated that she never got a satisfactory explanation from BCBSM why her son's dental care was not covered. She believes that she did everything to determine if her son's care was a covered benefit. She argues there was miscommunication about the difference between a participating provider and a network provider. She wants BCBSM to pay for her son's dental care.

Director's Review

It is not clear from the material submitted by BCBSM what certificate of coverage applies to the Petitioner's benefit plan. In the final adverse determination (prepared for BCBSM by Dental Network of America) the certificate is identified as the *Blue Dental EPO Personal Policy*. A copy of that policy was not submitted to the Director for this review. In BCBSM's position paper submitted for this review, BCBSM identified the Petitioner's policy as the *Blue Dental Individual Market Certificate*. However, BCBSM also states that the *Blue Dental EPO* policy applies. No explanation has been offered by BCBSM as to how these two policies are related.

It cannot be determined, based on BCBSM's submissions to the Director, whether either of the policies was provided to the Petitioner. Consequently, it cannot be established that the Petitioner's family was given notice of any restrictions in their choice of a dental provider.

In light of these facts, and in the absence of any explanation of the relationship between the two policies, and given BCBSM's failure to produce a copy of the *Blue Dental EPO* policy, the Director will apply the terms of the *Blue Dental Individual Market Certificate* to this appeal.

The *Blue Dental Individual Market Certificate*, on page 23, provides that BCBSM will pay dental benefits regardless of the provider's participation status:

Choosing A Dentist

Under most Blue Dental plans, you may choose any dentist. However, your out-of-pocket cost is less when you select a Blue Dental PPO dentist. There are some Blue Dental plans which require you to receive care from in-network providers only.

Our payment will vary based on whether your dentist is a PPO dentist, a non-PPO dentist who participates with us on a per-claim basis (a participating dentist) or a non-participating dentist. PPO dentists agree to accept our PPO fee and participating dentists agree to accept our approved amounts as payment in full for covered services. Therefore, you must always ask whether your dentist is a Blue Dental PPO dentist or if he or she agrees to participate with us for every service provided.

If your dentist is nonparticipating and indicates that he or she will not participate with us for a particular service, then you are responsible for any costs that exceed our reimbursement for that service.

* * *

Nonparticipating Dentist

If a non-PPO dentist chooses not to participate on a claim, we will pay you directly for covered services. Our payment will be the lesser of the amount billed or our approved amount. You are responsible for the entire amount billed by your dentist, which may be higher than our approved amount.

Since the *Blue Dental Individual Market Certificate* provides for payment for dental care provided by a nonparticipating dentist, the Director finds that BCBSM is obligated to provide coverage (its approved amount) for the Petitioner's dental treatment.

V. ORDER

The Director reverses BCBSM's November 17, 2014, final adverse determination. As required by section 1911(17) of the Patient's Right to Independent Review Act, MCL 550.1911(17), BCBSM shall immediately approve coverage for the Petitioner's July 23, August 11, and August 13, 2014 dental care. BCBSM shall, within seven days of providing coverage, furnish the Director with proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, toll free at (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 60 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director