

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. 145678-001

Blue Cross Blue Shield of Michigan
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On January 7, 2015, ██████████ (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 reviewed the request and accepted it on January 14, 2015.

The Petitioner's health care coverage is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). Her benefits are defined in BCBSM's *Blue Cross Premier Gold Benefits Certificate*. The Director notified BCBSM of the external review request and asked for the information used to make its decision. The Director received BCBSM's response on January 26, 2015.

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

On October 6, 2014, the Petitioner went to the emergency department of ██████████ Hospital in ██████████ with pain in her midsection. She underwent tests to determine the cause of her pain. She then was seen by a physician and released with pain medication. BCBSM provided coverage for the hospital services but denied coverage for the physician's services.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial level conference on November 24, 2014, and issued a final adverse determination December 15, 2014, affirming its denial.

III. ISSUE

Did BCBSM correctly process the claim for the physician services provided in the hospital emergency department?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination issued to the Petitioner, BCBSM's representative wrote:

You are covered under the *Blue Cross Premier Gold Benefits Certificate*. On page 61 of your Certificate, under **Section 3: What BCBSM Pays For, Office Visits** it states:

We do not pay for:

- Out-of-network office visits

Procedure code 99205 (Office/outpatient visit, new patient, 60 minutes) is not a covered benefit when performed by an out-of-network provider. On October 6, 2014, you received your professional office visit service from [REDACTED], who is an out-of-network provider. Therefore, you remain responsible for the non-covered charge of \$274.00.

Petitioner's Argument

In a letter to BCBSM included with the request for an external review, the Petitioner wrote:

First, I usually see [REDACTED], who practices at [REDACTED] Hospital in [REDACTED]. I was placed on the liver transplant list in 2005. I have seen [REDACTED] as my liver specialist since that time. However, if a problem arises and I can't get to [REDACTED] to see him I see [REDACTED], a physician in [REDACTED]. On October 6, I called [REDACTED] due to having pain in my side (liver area). He felt it was important that I be seen and he was not in on that date. His office instructed me to go to the emergency services at [REDACTED], since he was a doctor that practiced at [REDACTED].

I went to emergency at [REDACTED] and sat waiting to see someone for over 8 hours. During that time, there were many tests done. All through these tests I did not see a doctor. After approximately 11 hours there and after several doses of morphine for the pain, a woman walked in and indicated she was a doctor and had looked at all my tests and was unable to find any reason for the pain and was sending me home with pain meds, and instructions to see my physician for a follow up.

Never during that time was I asked which doctor I wanted to see nor told which doctor I was going to see. If I signed anything indicating I gave my permission to see a specific doctor, I would not remember, I was on pain meds.

BCBS has now refused to pay for the doctor's portion of the bill because the doctor is not a BCBS participating doctor. I had no idea that a participating hospital would allow a non-participating physician work for them. The only reason I went to the most busy hospital,

where I knew I would have to spend a lot of time, was because I knew the hospital was a participating hospital!

For those reasons I feel the doctor bill should be covered by BCBSM.

Director's Review

The *Premier Gold* certificate does exclude coverage for out-of-network office visits, as BCBSM notes in its final adverse determination. However, the certificate also includes other provisions which apply specifically to emergency department services:

Emergency Treatment

* * *

Locations: We pay for services to treat medical emergencies and accidental injuries in a hospital, participating ambulatory surgery facility, urgent care center or physician's office subject to the conditions described below. (A participating ambulatory surgery facility is considered an in-network provider.)

We pay for:

Facility and physician services to examine and treat a medical emergency or accidental injury.

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PPO Out-of-Network Providers

When you receive covered services from an out-of-network provider, you will be required to pay a coinsurance and copayment for most covered services after your out-of-network deductible requirement has been paid...unless you were referred to that provider by a PPO in-network provider. (You must obtain the referral before receiving the referred service or the service will be subject to the out-of-network deductible, coinsurance and copay requirements)

NOTE: You will not be required to pay the out-of-network copays or coinsurance if:

- You receive covered services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office...

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BCBSM's denial of coverage for the services provided by [REDACTED] is based solely on the use of the CPT code 99205. This code applies to an office visit. The Petitioner has pointed out to BCBSM throughout the grievance and appeal process, that her encounter with [REDACTED] was in the emergency department of [REDACTED] during the course of her emergency treatment there on October 6, 2014. BCBSM failed to acknowledge that fact both in its final adverse determination and in its position statement submitted to the Director for this external review. The Director finds that the claim for [REDACTED] services was payable under the emergency treatment provision of the Petitioner's certificate of coverage.

CPT code 99205 is one of a number of codes that describe various forms of "evaluation and management" (*Current Procedural Terminology*, page 11).¹ The manual's evaluation and management

1. Medical procedures performed by physicians and other health care providers are classified with each procedure given a five-digit code number. This system was established by the American Medical Association which publishes

codes are divided into 19 categories. Among those categories are: office or other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, and critical care services. CPT code 99205 is classified as an “office or other outpatient services” code. [REDACTED] services are more accurately classified as emergency department services.

It is understandable that BCBSM might initially deny coverage when it received a claim coded as 99205 since the code refers to an office visit and [REDACTED] is a non-network provider. However, once the Petitioner documented that the treatment by [REDACTED] was part of her emergency department care, BCBSM was obligated to correct the coding error and provide the coverage the Petitioner was entitled to receive for emergency treatment. As noted above, emergency treatment is a covered benefit, even when received from an out-of-network provider.

V. ORDER

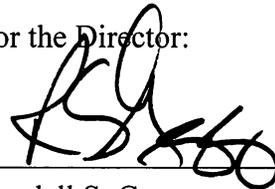
The Director reverses BCBSM’s December 15, 2014 final adverse determination. As required by section 1911(17) of the Patient’s Right to Independent Review Act, MCL 550.1911(17), BCBSM shall immediately approve coverage for the care the Petitioner received from [REDACTED] on December 6, 2014, subject to any cost sharing requirements identified in the Petitioner’s certificate of coverage. 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. 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 Michigan 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 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