

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. 145865-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 12<sup>th</sup> day of February 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On January 21, 2015, ██████████ on behalf of her minor 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 January 28, 2014.

The Petitioner receives dental care benefits through a group 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. The Director received BCBSM's response on February 9, 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**

The Petitioner's dental care benefits are defined in BCBSM's *Dental Options Group Benefit Certificate*<sup>2</sup> (the certificate).

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<sup>1</sup> ██████████

<sup>2</sup> BCBSM form no. 4943, approved 01/14.

The Petitioner was missing teeth #20 and #29 from birth but, at age 9 years, he still had primary (baby) teeth K and T. He was referred to an oral surgeon for hemisections, a procedure to divide teeth K and T as a way of keeping them and closing the space where teeth #20 and #29 should have been. The hemisections were performed on July 25, 2014, under conscious sedation. The charge for the surgery was \$682.00

When BCBSM denied the claim for the hemisections, the Petitioner appealed through BCBSM's internal grievance process. At the conclusion of that process BCBSM issued a final adverse determination on December 12, 2014, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### **III. ISSUE**

Did BCBSM correctly deny coverage for the Petitioner's hemisections?

### **IV. ANALYSIS**

#### Petitioner's Argument

In a January 14, 2015, letter submitted with the external review request, the Petitioner's mother wrote:

Earlier last year, [the Petitioner] was seen by an orthodontist and it was determined that he is congenitally missing two permanent teeth. We consulted with two separate orthodontists and it was recommended that we see an oral surgeon to consider having a hemisection of these two teeth, removing the back portion of the teeth allowing the back teeth to move forward while holding the front teeth in place, thereby closing the space.

At the time we saw the orthodontist, we did not have dental insurance, but the open enrollment period for my husband's employer was approaching. We called the oral surgeon's office to inquire about the procedure and were given the procedure codes. We then consulted with BCBS to determine if the procedures were covered. When we learned that it was, we enrolled in BCBS dental. In the past, we have always paid out of pocket for our routine preventive dental care and would have continued to do so had we known that this procedure was, in fact, not covered.

After we enrolled with the dental plan, but prior to [the Petitioner] having the procedure performed we were told by [the oral surgeon's office] that they had verified that the procedure would be covered at 80% of allowed charges. At this point, we agreed to have the procedure performed and paid up front the 20% in

the amount of \$218.00. It was not until we received the first EOB from BCBS that we learned that the procedure had not been covered.

When I called BCBS, I was told that the oral surgeon's office needed to submit X-rays and a narrative report - but that they should have known to differentiate that these were primary teeth. On 10/10/14, I received a second EOB from BCBS once again stating that the charges were being declined. On 10/15/14, I received a bill from the oral surgeon's office (the first I had received) stating that the account was at 61-90 days and that we owed \$428.25. I called the surgeon's office and was told that it was the fault of BCBS for not letting them know that primary teeth were not covered for this procedure. BCBS told me that the surgeon's office should have known to specify the type of teeth.

In hindsight, I am not sure what, if anything I could have done to avoid being in this predicament. We relied on their office to verify coverage and also attempted to independently verify coverage with BCBS using the code we were given. It seems to me that there was a significant misunderstanding between the office and BCBS. I'm not sure if BCBS should have specified that the policy would not cover primary teeth or if the office should have specified which teeth were being extracted. I do know, however, that had we known that the procedure wasn't covered, we would not have had the procedure performed at this time. As it is, we have now been billed not only for this procedure but also our monthly dental premiums.

### BCBSM's Argument

In its final adverse determination, BCBSM told the Petitioner's mother:

On behalf of [BCBSM], a consultant from Dental Network of America has reviewed your request to reconsider benefits for the above mentioned claim.

Your request for reconsideration of the previous benefits provided for this service has been denied. According to BCBSM guidelines, Hemisection on primary teeth are not a benefit. This determination was based on a review of the claim and the documentation provided.

### Director's Review

The Petitioner's dental plan covers endodontic services, including hemisections. However, hemisections are covered only for permanent teeth. The certificate (p. 3.8) says:

We pay our approved amount for the endodontic services listed below when performed by a dentist to treat disease of the tooth pulp and apical structure (root tip).

\* \* \*

- **Hemisection** for permanent teeth (surgical separation of a root of a multi-rooted tooth) payable once per tooth per lifetime [underlining added]

The hemisections performed on July 25, 2014, were on primary teeth K and T, not on permanent teeth. Therefore, the Petitioner's hemisections are not a benefit under the certificate.

It is unfortunate that complete and correct information about the hemisection benefit and the teeth involved was not known by everyone involved in the decision to proceed with the surgery. Nonetheless, in an external review under the Patient's Right to Independent Review Act, the Director can only determine if a denial of benefits was correct under the terms and conditions of the insurance contract and state law. The Director does not have the authority to amend the certificate based on misunderstandings or misinformation.

Here, the Director concludes and finds that BCBSM was correct when it denied coverage for the Petitioner's hemisections.

#### V. ORDER

The Director upholds Blue Cross Blue Shield of Michigan's December 12, 2014, final adverse determination.

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:

  
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Randall S. Gregg  
Special Deputy Director