

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. 146419-001-SF

████████████████████

Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,
Respondents.

Issued and entered
this 12th day of March 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 20, 2015, ██████████ authorized representative of his wife ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On February 27, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a group health plan sponsored by ██████████ University (the plan), a governmental self-funded plan as defined in Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director immediately notified BCBSM of the external review request and asked for the information used to make its final adverse determination. The Director received BCBSM's response on March 4, 2015.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901, *et seq.*

This case involves a contractual issue. 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 health care benefits are described in the plan's *Member Handbook*¹ (the handbook).

On September 24, 2014, the Petitioner was taken by air ambulance from [REDACTED], to a hospital in [REDACTED], for emergency treatment. The charge for the transport was \$46,011.00. The air ambulance service is an out-of-network provider, i.e., it does not participate with BCBSM or another Blue Cross or Blue Shield plan. BCBSM's "approved amount" for the services was \$12,083.70 (\$5,136.61 for "fixed wing air transport" and \$6,947.09 for "fixed wing air mileage") and it paid that amount to the Petitioner. The Petitioner was left responsible out-of-pocket for the balance of \$33,927.30.

The Petitioner appealed BCBSM's payment amount through its internal grievance process. BCBSM held a managerial-level conference on January 8, 2015, and issued a final adverse determination dated January 14, 2015, affirming its position. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Is BCBSM correctly process the claims for the Petitioner's air ambulance transport?

IV. ANALYSIS

BCBSM's Argument

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

... After review, I confirmed that the payment determination was appropriate, and additional reimbursement beyond our approved amount of \$12,083.70 is not warranted. In addition, payment was denied for procedure code A0398 (routine supplies) because these are considered inclusive of the base rate and are not a benefit when billed separately.

* * *

Page 14 of the *Health Care Handbook* addresses transportation by nonparticipating providers. Subsection **Nonparticipating Providers** explains:

¹ Revised 1/29/2014.

Nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services

You are usually required to pay nonparticipating providers directly and then you will submit the claim to BCBS for reimbursement. Remember, the amount BCBS reimburses you may be less than the amount your provider charged. You are responsible for the amount the provider charged above the BCBSM approved amount.

Page 53 of the *Health Care Handbook* goes on to explain that "charges from a nonparticipating provider that are in excess of the BCBS approved amount" are an exclusion of the plan.

As you are aware, [the air ambulance provider] is a nonparticipating provider with BCBS and is not obligated to accept the BCBS approved amount as payment in full. Our payment to you of \$12,083.70 is the maximum payment available; additional reimbursement cannot be made.

Petitioner's Argument

On the external review request form the Petitioner's authorized representative said:

Payment for emergency air ambulance transport have not been fully paid by insurer, nor has any attempt to negotiate a settlement between insurer and service provider been attempted, in violation of the terms and conditions of patient's Member Handbook. As a result patient is being billed approximately \$34,000 by service provider. After a complaint was filed with DIFS and a managerial level conference was conducted, the insurer, BCBS of MI, has denied the patient's appeal. We feel this decision was in violation of the contract and represents a severe threat to the patient's family and the healthcare system in Michigan's Western Upper Peninsula, therefore we request a Healthcare External Review by the Michigan Commissioner of Insurance and Financial Regulation and a determination directing BCBS to either pay the claim or resolve it with the service provider.

In a letter dated February 7, 2015, accompanying the request for an external review, the Petitioner's authorized representative also wrote:

On page 14 of the Member Handbook for employees of [REDACTED] [REDACTED] . . . it states, "If you receive treatment from an out-of-network provider for a medical emergency or accidental injury, your services will be paid at the in-network benefit level." A "medical emergency" is defined on page 72 of the Member Handbook to be "A condition that occurs suddenly and unexpectedly." Pursuant to page 23 of the Member Handbook, in-network ambulance services are

covered at the rate of 65% after the deductible. The in network deductible is \$2,000 per member. However, pursuant to that same page, there is an out-of-pocket maximum of \$3,000 per member. (see p. 23 of the Member Handbook)

. . . [The Petitioner] experienced a "medical emergency" on September 24, 2014. As a result of that medical emergency, she needed to be transported by air to [REDACTED] Hospital in [REDACTED] . . .

In accordance with page 14 of the Member Handbook . . . section title Emergency Services by Out-of-Network Providers, Blue Cross Blue Shield ("BCBS") is required to pay [REDACTED] at the "in-network" level because [the Petitioner] experienced a medical emergency. This would mean that BCBS is required to pay 65% of the emergency transportation bill . . . after the payment of the \$2,000 deductible, and 100% of the transportation bill once the out-of-pocket maximum of \$3,000 is reached. However, BCBS has, thus far, only paid \$12,087.68 to service provider . . . of their \$46,011.00 bill . . . and has also failed to negotiate any resolution with [the provider]. This is not right, and violates the terms and conditions of the Member Handbook. BCBS must be required to pay the remaining amount of \$33,923.32 due . . . or negotiate a resolution . . . that removes any additional financial responsibility on this claim from [us] beyond what remains of their out-of-pocket maximum, as defined in the Member Handbook.

BCBS seems to assert that, because [the provider] is an out-of-network provider, it only has to pay . . . the amount that BCBS deems reasonable, and that [we are] responsible for the remaining \$33,923.32 due. As set forth above, this assertion ignores the fact that [the Petitioner] experienced a medical emergency, and that BCBS is therefore required under its contract with us to pay [the provider] as an in-network provider. However, even if one were to find some way to interpret the Member Handbook so as to be able to ignore the requirements clearly specified on page 14 in the Emergency Services by Out-of-Network Providers section, BCBS's assertion is still incorrect. According to page 23 of the Handbook, if we obtain (non-emergency) services from an out-of-network provider, our out-of-pocket maximum is \$8,000 per member (including deductibles, coinsurance and copays).

. . .

Director's Review

There is no dispute in this case that emergency air ambulance transport was a medically necessary covered benefit in this case. The sole issue is how much the plan must pay for the service.

The handbook (p. 18) explains that BCBSM pays, on behalf of the plan, an "approved amount" for covered benefits:

Payment of Benefits

Your coverage consists of services and supplies for which BCBS agrees to pay under the terms of your employer's coverage documents. Payable services and supplies are called "benefits" and are listed in your employer's coverage documents.

The payment amount for these benefits is called the "approved amount." This is the BCBS maximum payment level allowed for the covered services. Deductibles, coinsurances and copayments and sanctions are deducted from the approved amount. All references to the approved amount in this handbook refer to the approved amount as determined by BCBS.

“Approved amount” is defined in the handbook (p. 69):

The BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

The plan's maximum payment amount, as determined by BCBSM, for the Petitioner's air ambulance transport was \$12,083.70. Because that amount was lower than the provider's charge of \$46,011.00, it became BCBSM's "approved amount" and the basis for calculating its payment. There is no requirement in the handbook that the plan must base its payment on the provider's charge or on the average amount charged for similar providers.

The approved amount is the same amount that BCBSM would have paid a participating provider. However, unlike participating providers, nonparticipating providers (the air ambulance service in this case) have not agreed to accept BCBSM's approved amount as payment in full for the covered service. The handbook (p. 14) says:

Nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services.

Regarding nonparticipating providers, the handbook further says (p. 18):

Remember, the amount BCBS reimburses you may be less than the amount your provider charged. You are responsible for the amount the provider charged above the BCBS approved amount.

Finally, the handbook (pp. 53-54) has this provision under "PPO Exclusions and Limitations":

In addition to the exclusions and limitations listed elsewhere in this handbook, unless otherwise stated, the following exclusions and limitations apply:

* * *

- Charges from a nonparticipating provider that are in excess of the BCBS approved amount.

The handbook (p. 14) says that emergency services received from out-of-network providers will be paid at the in-network benefit level. According to the handbook (p. 23), medically necessary in-network ambulance services are covered at 65% after the deductible. The explanation of benefits statement dated November 28, 2014, shows that BCBSM paid 100% of its approved amount and did not apply a deductible or other cost sharing.

The Petitioner points out that the handbook (p. 23) says that the out-of-pocket cost for in-network services is limited to \$8,000.00 per member or \$16,000 for a family. But out-of-pocket costs are deductibles, coinsurance, and copayments – the term does not include amounts in excess of BCBSM’s approved amount that the Petitioner may owe to a nonparticipating provider.

It is unfortunate the Petitioner experienced a medical emergency and had to use a nonparticipating provider for air transport. Nevertheless, there is nothing in the handbook or in state law that requires BCBSM to pay a nonparticipating provider more than its approved amount, even under the circumstances of this case. The Director concludes that BCBSM correctly processed the claims for the Petitioner’s air ambulance transport.

V. ORDER

The Director upholds BCBSM’s final adverse determination of January 14, 2015.

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 sixty days from the date of this order in the circuit court for the Michigan 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