

**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. 147434-001**

**Blue Cross Blue Shield of Michigan,**

**Respondent.**

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**Issued and entered**  
**this 11<sup>th</sup> day of May 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On April 20, 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.* On April 27, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits under a group plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director immediately 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 May 5, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. See MCL 550.1911(7).

**II. FACTUAL BACKGROUND**

The Petitioner's health care benefits are defined in BCBSM's *Community Blue Group Benefits Certificate*<sup>1</sup> (the certificate). The certificate is amended by *Rider CBD \$500-IN LG Community Blue Deductible Requirement for In-Network Services* (the deductible rider) and

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<sup>1</sup> BCBSM form no. 679E, approved 08/14.

*Rider CBC 20%-IN LG Community Blue Coinsurance Requirement for In-Network Services (the coinsurance rider).*

The Petitioner was scheduled for kidney stone surgery (CPT code 50590, "lithotripsy, extracorporeal shockwave") on October 22, 2014, at an ambulatory surgery facility. The procedure was cancelled before it was completed. Nevertheless, the facility submitted a claim for its services, which BCBSM processed. The claim was processed with the diagnosis codes 592.1 (calculus of ureter) and V64.3 (procedure not carried out for other reasons).

BCBSM's approved amount for the facility charge was \$2,360.76. It applied \$426.12 of that amount to the Petitioner's annual deductible for in-network services, applied \$386.93 in coinsurance, and then paid the provider \$1,547.71. The Petitioner was left responsible out-of-pocket for a total of \$813.05.

The Petitioner appealed BCBSM's processing of the claim through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 16, 2015, upholding its payment decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly process the Petitioner's October 22, 2014 lithotripsy and related services claim?

### IV. ANALYSIS

The Petitioner does not believe that he should be responsible for his full cost share for the facility charge for a procedure that was never completed. In a December 30, 2014, appeal letter to BCBSM that was filed with his request for an external review, the Petitioner explained his position:

I have been suffering with lower right quadrant back pain since 7/9/14. After a visit to the [REDACTED] ER on 7/18/14, I was diagnosed with a 5mm kidney stone and told to follow up with a Urologist. Over the next 2 months, I had several visits with [a urologist] from the [REDACTED] [REDACTED] and received several x-rays. I had an x-ray on 9/4/14 and was seen by [the urologist] on 9/10/14, upon which time, due to the constant discomfort and pain I was suffering from the kidney stone, it was mutually decided to try the Laser Shock Wave procedure to break up the stone. The original procedure was scheduled for 9/24/14, but I had to cancel and reschedule due to an illness. Due to the fact that these procedure[s] are apparently only performed every other Wednesday, the next date available was 10/8/14. Due to the time they scheduled

and a miscommunication of them not providing a different time for 10/1/14, the procedure again had to be postponed until two weeks later on 10/22/14.

On 10/22/14, due to the postponed dates, the procedure was scheduled to be performed by a [doctor] whom I had never seen before. After the initial preparation for the surgery, I was visited by [the doctor] and rudely asked why I hadn't brought x-rays with me, to which I responded I was not told this was necessary in my numerous phone calls with the surgical staff or by [my urologist] and I had assumed all x-rays were accessible through [REDACTED]. He then stated that he would see what he could do by looking for the stone with an x-ray but no guarantees. My wife was then seen in the waiting room by [the doctor] not even 5 minutes after leaving me for the procedure, and told they couldn't find the stone with the x-ray, so no procedure was performed and I should follow up . . . in two weeks. Before leaving the facility, my wife asked about the \$472.15 co-pay that was collected upon our arrival that day since the procedure was not performed. After a brief wait, the front desk receptionist contacted the billing department and someone from billing came down to the surgical office and told them to refund the entire co-pay since the procedure was not performed.

Imagine my surprise when I received [BCBSM's] Explanation of Benefit Payments and a bill from [the ambulatory surgery facility] showing I owe \$813.05 for a procedure which was never performed. After several phone calls to both Blue Cross Blue Shield of Michigan and the billing department of [surgery facility], I was told that I must appeal to BCBSM. Not only am I still suffering with the same discomfort and pain, I am stuck with a bill for \$813.05. I do not understand why BCBSM was charged \$4,665 and paid this provider \$1,547.71 for this service. [REDACTED] also billed a separate charge on 10/22/14 for \$150 for the x-ray that was performed during this time.

\* \* \*

. . . While I understand there should be some sort of charge for this day, I do not believe the same amount should be billed and paid whether the procedure is performed or in this case not performed.

BCBSM, however, says the service is covered even if the procedure is discontinued. In its final adverse determination, BCBSM's representative explained its position to the Petitioner:

. . . After review, the payment level is maintained. I confirmed the procedure was billed properly. The provider may bill for the use of the facility for cancelled or incomplete surgical procedures. Because your deductible and out of pocket maximum had not been met at the time of the service, the approved amount applied to them. You remain liable for the contractual deductible in the amount of \$426.12 and coinsurance in the amount of \$386.93 to the [surgery center]. Let me explain further.

You are covered under the *Community Blue Group Benefits Certificate*. As described on page 99 of your certificate, you are covered for surgical procedures in freestanding ambulatory surgery facilities. Page 10 of your certificate states that you are required to pay a yearly deductible for covered services before Blue Cross Blue Shield of Michigan (BCBSM) begins to share in health care costs. *Rider CBD \$500-IN LG Community Blue Deductible Requirement for In-Network Services* amends this provision to set your in-network deductible at \$500.00 for an individual, and \$1,000.00 for a family of two or more. As described on page 13 of your certificate, you must pay coinsurance (percentage) amounts for covered services. *Rider BCB 20%-IN LG Community Blue Coinsurance Requirement for In-Network Services* amends this provision to set your coinsurance level at twenty percent of covered services.

The service billed by the provider on October 22, 2014 was 50590 (lithotripsy, extracorporeal shock wave). This service is a surgical procedure performed at an ambulatory surgery facility and, as described above, is a covered benefit, payable by BCBSM, subject to your contractual deductible and coinsurance requirements.

The charges billed by the provider for this service are for use of the facility for the procedure. According to the BCBSM *Provider Manual for Ambulatory Surgical Facility Services*, for incomplete or cancelled surgery claims, the facility claims are paid as if they had resulted in a completed surgery. This means that the provider may charge for the use of the facility itself, even if the procedure is cancelled or incomplete.

BCBSM cited a provision in its provider manual chapter for ambulatory surgery facility services which indicates that cancelled surgery can still be covered:

**Incomplete (canceled) surgery**

For incomplete (canceled) surgery claims, ambulatory surgery facilities are required to report:

- The procedure code for the planned surgery
- The primary ICD diagnosis code, as well as the appropriate secondary ICD diagnosis code to describe the reason for cancellation of the surgical procedure

Claims are paid the same way - that is, the lesser of approved charges or the prevailing fee - and in the same amount as a completed surgery. [Underlining added]

The Petitioner says the surgery was eventually cancelled because no X-rays were available. But the surgeon did attempt to undertake the procedure. The surgeon's operative report said:

OPERATION PERFORMED: Observation under fluoroscopy and ultrasound to find the stone.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed on the lithotomy table. The right ureteral calculus that was last seen on x-ray a month ago was not found from the kidney, which had no hydronephrosis, all the way down to the bladder. The procedure was terminated, and the patient was sent to the recovery room. He is to return to the office in 2 weeks preceded by a KUB [*kidney, ureter and bladder*] x-ray for comparison.

The provider manual does not explain if there are any reasons for cancellation that would justify a decision by BCBSM not to pay a claim. In this case, BCBSM accepted the facility's reasons for the cancellation and processed the claim, presumably because the facility was used even though the procedure ended prematurely. There is nothing in the certificate that says an ambulatory surgery facility charge must be waived or adjusted if a procedure is cancelled or discontinued.

The Director has no basis to overturn BCBSM's decision in this case. The Petitioner received services in an ambulatory surgery facility and the Director finds that BCBSM correctly processed the claim for those services under the terms and conditions of the certificate.

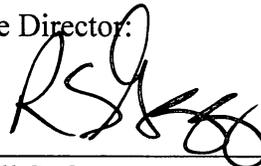
#### V. ORDER

The Director upholds BCBSM's final adverse determination of February 16, 2015.

This is a final decision of an administrative agency. 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 Michigan county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1). 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