

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. 148130-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 23<sup>rd</sup> day of June 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On May 29, 2015, ██████████, authorized representative of ██████████ (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.* After a preliminary review, the Director accepted the request on June 5, 2015.

The Petitioner receives health care benefits through 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. BCBSM provided its response on June 10, 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**

At the time the Petitioner received the service that is in dispute in this case, his health care benefits were defined in BCBSM's *Simply Blue Health Savings Account Group Benefits Certificate with Prescription Drugs* (the certificate).<sup>1</sup>

On September 6, 2013, the Petitioner was transported by air ambulance from ██████████

██████████ The air ambulance

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<sup>1</sup> BCBSM form no. 685C, approved 10/12.

provider, PHI Air Medical (PHI), does not participate with BCBSM or a local Blue Cross or Blue Shield plan in [REDACTED] (the “host plan”).

The charge for the transport was \$46,807.00. Based on the host plan’s determination, BCBSM initially approved that amount as its payment.<sup>2</sup> However, BCBSM subsequently determined that it had paid the claim in error. It reprocessed the claim, approving only \$11,843.26 for the air transport.<sup>3</sup> This left the Petitioner responsible for the balance of \$34,963.74.

The Petitioner appealed BCBSM’s payment decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 30, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly process the claim for the air ambulance transport?

### IV. ANALYSIS

#### Petitioner’s Argument

In an undated letter accompanying the request for an external review, the Petitioner said:

I was admitted to the [REDACTED] Intensive Care Unit on September 2, 2013 where I was placed in medically induced coma. My condition deteriorated over that week until I was diagnosed on September 6, 2013 with a ruptured mitral valve and aspiration pneumonia, both life threatening conditions. [My doctor], the attending cardiologist at [REDACTED] recommended due to my serious, life threatening condition that my best chance for survival was transportation via life-flight helicopter to [REDACTED]. [My doctor] and Henry Ford Staff arranged for emergency transport to [REDACTED] with PHI Air Medical Services. PHI successfully provided the services and [REDACTED] [REDACTED] without a doubt saved my life.

\* \* \*

Since the life-flight services were provided, BCBS of Michigan has denied, then agreed to pay, and then denied again an approved claim and cancelled a BCBS issued check for the services PHI provided. Per the . . . Benefits-at-a-Glance which summarizes covered services on my in force PPO health plan at the time of the crisis, emergency ambulatory care is covered 80% after in-network deductible is met for both in and out-of-network services. Per the . . . EOB, my annual

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2 See October 20, 2014, explanation of benefit payments statement.

3 See November 14, 2014, explanation of benefit payments statement.

deductible (family coverage) and annual out-of-pocket maximum (family coverage) was applied both in and out of network. My out-of-pocket medical expenses were satisfied for the year, my obligation met.

After numerous hours of working with [BCBSM's] claims department in an attempt to get this claim paid for PHI Air Medical, the claim was finally approved and a check issued for the remainder of funds due (\$34,963.74) dated 10/20/2014. Due to the failure of [BCBSM] to timely process this claim (after more than a year passing), PHI Air Medical brought legal action against me seeking full compensation for services rendered in a lawsuit. Upon receipt of the aforementioned check . . . in the amount of \$34,963.74, I reached an agreement with PHI Air Medical and their legal counsel. This legal agreement was agreed to and filed with and accepted by the circuit court of [REDACTED] [REDACTED]

[The attorney] for PHI Air Medical attempted to cash the check on behalf of PHI. The processing of the check was refused. [The attorney] contacted me and indicated he was told I had to process the check myself (due to the check being issued in my name). Since [BCBSM] issued the check from a Bank of America account, which is my bank, I agreed to meet [the attorney] in person at a Bank of America branch, deposit the check into my account, after which I would issue a cashier's check to his firm for the full amount of the check. I met [the attorney] as agreed at a Bank of America branch in [REDACTED] and attempted to do as agreed. That is when I was told by Bank of America staff that the check had been cancelled. Two days after this occurred, I received [a] letter stating [BCBSM] was seeking reimbursement for the check. . . .

Because of [BCBSM's] actions in cancelling the check that had already been issued, I am now in violation of a legal order/agreement. [BCBSM] has mishandled this case, causing undue stress and anxiety on me and my family, caused unnecessary legal action and considerable unnecessary financial expense while delaying and eventually denying payment to a service provider that entitled life to be saved. I am entitled to coverage for the service PHI Air Medical provided. It was medically necessary per [BCBSM], and [REDACTED] [REDACTED] (participating facility of [BCBSM]) doctors.

I am entitled to the full benefit I subscribed and paid for with [BCBSM]. I simply request that [BCBSM] restore the original approval of the claim and reissue the check previously approved for payment to PHI Air Medical in the amount of \$34,963.74 so I may bring this entire matter to a close.

### BCBSM's Argument

BCBSM's representative explained its position to the Petitioner in the final adverse determination:

After review, I confirmed that [BCBSM] processed and paid this claim at the network benefit level and approved the maximum amount allowed (\$11,843.26)

for these services. No additional payment can be made. The non-covered charges totaling \$34,963.74 remain an issue between you and the provider.

\* \* \*

Page 8.20 of the *Certificate* defines nonparticipating providers as physicians and other health care professional or Facilities that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full.

I confirmed that PHI Air Medical is a nonparticipating professional provider. As stated above, nonparticipating providers are not required to accept our approved amount as payment in full.

According to our records, a check for our approved amount of \$11,843.26 was issued to you on March 10, 2014 and cashed on March 20, 2014. As noted above, this is our maximum payment amount for the services you received.

I understand that you were issued a check in the amount of \$34,963.74 on October 20, 2014 as reimbursement of the outstanding balance for the services you received. However, it was determined that your claim had originally processed correctly, [sic] and that this additional payment was made in error. As a result, payment on this check was voided on November 19, 2014. The claim was corrected and the reimbursement amount was adjusted to reflect the correct maximum amount payable for the service (\$11,843.26). Because this payment was already made to you on March 10, 2014, no further payment is available.

While I understand your frustration, and that you would like additional payment approved for these services, BCBSM must administer your benefits in accordance with the terms of your coverage. The remaining balance owed remains an issue between you and the provider.

#### Director's Review

Ambulance transport, including air ambulance transport, is a benefit under the certificate when certain conditions are met (pp. 5.4-5.5). There is no dispute in the record that the Petitioner qualified for air ambulance transport under those conditions. The only dispute is over the amount BCBSM paid for the service.

The certificate (p. 5.4) explains that BCBSM pays its "approved amount" for ambulance services. "Approved amount" is defined in the certificate (p. 8.2): "The lower of the billed charge or our maximum payment level for the covered service." BCBSM's maximum payment level for the air ambulance transport was finally determined to be \$11,843.26. Since that amount was lower than the provider's billed amount, it became BCBSM's approved amount for the service. If PHI Air Medical had been a participating provider, it would have accepted \$11,843.26 as payment in full for the air transport.

Under the terms of the certificate, the least out-of-pocket cost is incurred if services are rendered by a "panel provider," a health care professional that provides services through the Peti-

tioner's PPO program. Unfortunately, the air ambulance provider is not a panel provider and furthermore does not participate with BCBSM, i.e., it had not "signed a participation agreement with BCBSM to accept the approved amount as payment in full." Consequently, it could bill the Petitioner for any amount of its charge above BCBSM's approved amount. The certificate (p. 4.9) explains the consequences when a nonparticipating provider is used:

If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to you.

**NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

There is nothing in the certificate that requires BCBSM to pay more than its approved amount for the air ambulance service, even if the Petitioner had no choice in the selection of the air ambulance service, as it appears to be in this case.

The Director concludes that BCBSM correctly processed the air ambulance claim in accordance with the terms and conditions of the certificate when it paid the Petitioner its approved amount of \$11,843.26.

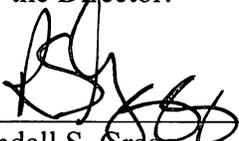
#### V. ORDER

The Director upholds BCBSM's final adverse determination dated March 30, 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 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. 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.

Patrick M. McPharlin,  
Director

For the Director:

  
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Randall S. Gregg  
Special Deputy Director