

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. 148140-001-SF

State of Michigan, Plan Sponsor

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

**Issued and entered
this 15th day of July 2015
by Joseph A. Garcia
Special Deputy Director**

ORDER

I. PROCEDURAL BACKGROUND

On June 3, 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.*, appealing a claim denial issued by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM is the administrator of the Petitioner's self-funded health benefit plan which is sponsored by the State of Michigan.

The request for external review was filed under Public Act 495 of 2006, (Act 495) MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The State of Michigan health benefit plan is such a self-funded plan. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952).

On June 9, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on June 17, 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

Medicare provides the Petitioner's primary health coverage. She receives benefits supplemental to Medicare as a dependent on her husband's State of Michigan benefit plan. Those benefits are described in BCBSM's *Benefit Guide* for Medicare-eligible retirees. The Petitioner had primary dental coverage through CIGNA that terminated December 31, 2013. She currently has dental coverage through Delta Dental Plan of Michigan.

On September 3, 2013, the Petitioner fell while on vacation in [REDACTED]. She cut her lower lip, damaged a tooth, and injured her wrist. She was treated initially at [REDACTED] Memorial Clinic in [REDACTED]. The [REDACTED] Clinic had no facilities or staff to treat dental injuries. She was advised to seek dental treatment as soon as she returned home. She later had extensive restorative dental work in [REDACTED] which was performed between September 10, 2013 and April 24, 2014. The charges totaled \$5,113.00.

Medicare denied coverage because it does not cover dental services. CIGNA processed the Petitioner's claims on November 12, 2013 and denied coverage because they considered the services to be medical in nature. Delta Dental paid for some of the services but denied coverage for the extraction, periodontal surgery, and implant.

In December 2014, BCBSM approved payment of \$247.60 for the dental surgery performed on September 10 and 17, 2013. BCBSM denied coverage for the services performed on April 29, 2014. The charge for that care was \$1,934.00. BCBSM ruled that the April 29 treatment had come after the six month limit to complete treatment for accidental dental injuries.

The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. At the conclusion of the internal grievance process, on April 17, 2015, BCBSM issued a final adverse determination affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's April 29, 2014 dental treatment?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination BCBSM wrote:

Blue Cross and Blue Shield of Michigan (BCBSM) approved and paid the charges incurred on September 10 and September 17, 2013. Our payment was issued to you in the amounts of \$216.00 and \$31.60, respectively, on December 8, 2014. Our approved amount is based on the balance remaining following payment approved by your dental carrier. Our records reflect that no patient liability remains.

With [regard] to the charges (\$1,934) for services performed on April 29, 2014, we are unable to authorize payment of the claim. Under the terms of coverage, we pay for accidental dental services up to 6 months from the date that the accident occurred. Because the accident occurred on September 10, 2013, according to the documentation we received, these services are outside the scope of the time-frame requirement, and therefore, are considered noncovered services. You remain liable for these charges.

Your Benefit Guide, State Health Plan PPO Medicare-eligible Retirees, Page 11 of Your Benefit Guide explains that dental treatment for accidental dental injuries is covered at 90% of the approved amount after your deductible has been satisfied. Accidental dental services are covered to provide relief of pain and discomfort following an injury, as well as repair of those injuries. The services must be completed within 6 months of the initial injury in order to be payable under the terms of coverage.

Page 48 of *Your Benefit Guide* defines the approved amount as 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 claim paid for the September services failed to apply your coinsurance requirement...The money will not be recalled at this time.

Petitioner's Argument

In her request for an external review the Petitioner wrote:

BCBS Senior Clerk [REDACTED] assured me my claim would not be denied because the final step of treatment would be more than 6 months away due to the bone graft needing time to "take." This was all part of the original claim dated 9-10-13.

In a letter submitted with her request for review, the Petitioner wrote:

My accident was a result of a fall I took while on vacation in [REDACTED]. No doctors, dentists, pharmacies or hospitals there. I was taken care of at [REDACTED] Memorial Clinic in [REDACTED]

My first step in returning to [REDACTED] was to see my doctor to have a cast put on my broken arm and then to see my dentist to have the broken-out tooth taken care of. Those procedures were taken care of on September 10, 2013, and September 17, 2013....

I probably should not have submitted any of this to my dental insurances as this was not routine or scheduled dental care, but rather the result of this accident.

Numerous calls were made to BCBSM to determine the outcome of my claim with various people telling me the documents were lost, not entered in the system, or that it was an accident and would be taken care of. Most of my claim was denied and I had to go to the appeal process....

Senior Customer Service Representative, [REDACTED], told me there was no concern because my final treatment of the broken tooth was beyond the 6 month period, April 29, 2014, that it was all part of the original claim and would still be considered. What on earth is going on with these people!

[REDACTED] even submitted a letter on my behalf explaining why this was the best solution to my accident....

I now appeal to your group to see that I am reimbursed for this final payment and perhaps even pay for what the dental insurances didn't because it was an unfortunate accident.

Director's Review

The BCBSM *Benefit Guide*, on pages 10 and 11, provides that, to be covered, emergency dental care must be completed within 24 hours of the accidental injury and follow-up care must be completed within six months of the injury to be payable. The Petitioner argues that BCBSM should cover the services provided on April 29, 2014 because they were the last phase of treatment from her accident and because a BCBSM representative assured her that the complete treatment would be covered even if it was provided beyond the six-month period in which accidental dental services must be completed.

In conducting reviews under the Patient's Right to Independent Review Act, the Director is limited to considering the terms and conditions of the applicable insurance policy, in this case the BCBSM *Benefit Guide*. The Director cannot consider oral statements made by an insurer's representatives which may be inconsistent with the written terms of coverage.

The *Benefit Guide* states that accidental dental services must be completed within six months of the initial injury. The Petitioner's injury occurred on September 3, 2013. The April 24, 2014 date of service is beyond the six-month limit for completing treatment.

The Director finds that BCBSM correctly processed the Petitioner claims for dental services related to her September 3, 2013 accident.

V. ORDER

The Director upholds BCBSM's April 17, 2015 final adverse determination. BCBSM is not required to provide additional coverage for the Petitioner's dental treatment.

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.

Patrick M. McPharlin
Director

For the Director:

A handwritten signature in black ink, appearing to read 'J. Garcia', is written over a horizontal line. The signature is stylized and cursive.

Joseph A. Garcia
Special Deputy Director