

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. 148197-001-SF

██████████ **County Road Commission, Plan Sponsor,**

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 30th day of June 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 8, 2015, ██████████, authorized representative of ██████████ (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 June 15, 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 (the plan) sponsored by the ██████████ County Road Commission, a governmental self-funded plan subject to 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 June 22, 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 BCBSM's *Comprehensive Health Care Copayment Certificate Series CMM ASC*¹ (the certificate). Several riders amend the certificate.

On September 1, 2014, the Petitioner was transported by air ambulance from a hospital in [REDACTED], to another hospital in [REDACTED]. The air ambulance provider, [REDACTED], does not participate with BCBSM or a Blue Cross or Blue Shield plan in [REDACTED] (the host plan).

The charge for the transport was \$35,900.84. BCBSM's "approved amount" for the transport was \$5,854.07. After applying a \$100.00 in-network deductible and \$575.41 in coinsurance, BCBSM paid the provider \$5,178.66. The Petitioner was left responsible out-of-pocket for \$31,397.59 (\$675.41 for the deductible and coinsurance and \$30,722.18 for the balance of the provider's charge).

The Petitioner appealed BCBSM's payment decision through its internal grievance process. BCBSM held a managerial-level conference on April 15, 2015, and issued a final adverse determination dated May 11, 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 Petitioner's air ambulance transport?

IV. ANALYSIS

Petitioner's Argument

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

[The Petitioner] was critically ill and was air lifted for an interfacility transfer. He was in a vulnerable, critical situation and trusted the recommendations of his doctors. He had no other choice or options but to be airlifted.

Under his group plan, ambulance transport is covered and his plan did pay a very small portion of the charged amount. BCBSM states they have paid their

¹ BCBSM form no. 452F, effective 07/14.

maximum allowed amount of \$5,178.66, and the provider is balance billing \$30,722.18. We are asking BCBSM to make additional payment to cover this service per the group plan.

The Petitioner also alleged that BCBSM's processing of the air ambulance claim was in violation of section 2719A of the federal Public Health Service Act, 42 USC § 300gg-19A, regarding emergency care.²

BCBSM's Argument

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

. . . After review, because payment has been made at the maximum payment level, no additional payment can be approved.

As a Grievance and Appeals Coordinator, I reviewed the claim, appeal, and [the Petitioner's] health care plan benefits for [BCBSM]. [The Petitioner] is enrolled in the *Comprehensive Health Care Copayment Certificate Series CMM ASC (Certificate)*. The certificate is amended by *Rider CMM-PPO*, which explains that when services are received from nonparticipating providers outside of our service area, a subscriber's liability will be calculated based on either the local Blue Cross Blue Shield Plan's (Host Plan's) maximum payment level, or the pricing arrangements required by applicable state law (Page 15). *Rider CMM-PPO* further explains that in this situation, the subscriber may be billed for the difference between the provider's bill and the Host's Plan's payment (page 15).

The certificate is amended by *Rider CMM-ECS-3*, which explains that ambulance services are subject to deductible and coinsurance requirements (Page 2). The *Certificate* explains that the coinsurance requirement is 10% of the applicable maximum payment level (Page 2.1, Section 2: What You Must pay). The *Certificate* is also amended by *Rider CMM-D*, which explains that [the Petitioner's] annual deductible requirement is \$100.00 (Page 2).

In this case, because [REDACTED] is a nonparticipating provider and the services were received outside of our service area, Blue Cross Blue Shield of [REDACTED] as the Host Plan, provided the maximum payment level for [the Petitioner's] transport. Specifically, [REDACTED] approved \$4,059.67 for the use of the air ambulance, and approved \$1,794.40 for the miles traveled, for a total of \$5,854.07.

As of the date of service, [the Petitioner's] annual deductible requirement had not been met; therefore, \$100 was assigned to his deductible responsibility. Also per

² The provision was enacted as part of the federal Patient Protection and Affordable Care Act.

the certificate's coinsurance requirement, \$574.42 was assigned to [the Petitioner's] coinsurance responsibility. Therefore, ██████ paid \$5,178.66, which represents the maximum payment level minus [his] deductible and coinsurance responsibility.

However, because ██████ has not agreed to accept the approved amount as payment in full, [the Petitioner] may be billed for the difference between the provider's charges and ██████ payment, for a total of \$30,722.18.

As indicated above, the payment determination processed correctly according to the requirements laid out in the *Certificate* and attached *Riders*, and therefore additional payment cannot be approved. I understand this decision is unfavorable to [the Petitioner]; however, payment determinations must adhere to the terms and conditions of [the Petitioner's] health care coverage, and I am unable to make an exception on his behalf.

Director's Review

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

The certificate (p. 5.6) explains that BCBSM pays, on behalf of the plan, its "approved amount" for ambulance services. "Approved amount" is defined in the certificate (p. 7.2) as

[t]he lower of the billed charge or our maximum payment level for the covered service. Deductibles, copayments and/or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Because the air ambulance transport occurred in ██████ BCBSM's maximum payment level was determined by the local host plan, ██████ ██████'s maximum payment level was \$5,854.07 and, because that amount was lower than the provider's charge of \$35,900.84, it became BCBSM's "approved amount" and the basis for calculating its payment to the provider.

It is unfortunate that the Petitioner had to use a nonparticipating provider for emergency transport because a participating provider would have accepted BCBSM's approved amount as payment in full (certificate, pp. 3.49-3.50)

BCBSM correctly processed the air ambulance claim. *Rider CMM-D \$100 ASC* amended the certificate to increase the deductible to \$100.00 for a member. *Rider CMM-ECS-3 ASC* explains that ambulance services are subject to the certificate's deductible and coinsurance requirements. Thus, BCBSM subtracted \$100.00 from its approved amount for the deductible.

Rider CMM-PPO 15% ASC added an additional 15% coinsurance requirement to the certificate for care or services from out-of-network providers. However, the rider also says (pp. 10-11) that the additional coinsurance is waived when the care or services are for a medical emergency, as in this case, but that the coinsurance in the certificate is still applicable.³ The certificate (p. 2.1) sets a 10% coinsurance for most covered services, including ambulance service, and that was applied. BCBSM's calculations are accurately reflected in the November 7, 2014, explanation of benefit payments statement.

The Petitioner argues that section 2719A of the federal Public Health Service Act applies in this case. However, that section is inapplicable because it concerns health care services provided in the emergency department of a hospital, not to emergency air ambulance transportation.

The Director finds that BCBSM correctly processed the claims for the Petitioner's air ambulance transport on September 1, 2014, according to the terms of the Petitioner's coverage.

V. ORDER

The Director upholds BCBSM's final adverse determination of May 11, 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.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director

³ *Rider CMM-PPO 15% ASC* also cautions (p. 10) that a subscriber may be liable for the difference between the nonparticipating provider's charge and BCBSM's approved amount.