

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. 149974-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 20th day of October 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) required surgery following an accident. The surgery was performed by an out-of-network physician. The Petitioner was dissatisfied with the amount paid by his health plan for the surgery claim.

On September 21, 2015, he filed a request with the Director of Insurance and Financial Services for an external review of the claim processing decision under the Patient's Right to Independent Review Act, MCL 550.1901 et seq. The Director made a preliminary review of the request and accepted it on September 28, 2015.

The Petitioner has group health care coverage through a 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 decision. The Director received BCBSM's response on October 5, 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

The Petitioner's benefits are defined in BCBSM's *Community Blue Group Benefits Certificate LG*.¹

¹ BCBSM form no. 679E, effective 2015.

On May 23, 2015, the Petitioner was involved in an accident and was taken to the emergency department of a hospital in [REDACTED], where he lives. After he was stabilized, he was transported to [REDACTED] where oral surgery was performed that same day in the office of a nonparticipating surgeon.

The surgeon charged \$4,170.00. BCBSM reimbursed the Petitioner for \$848.35, its approved amount, leaving him responsible for the balance of \$3,321.65. The Petitioner appealed BCBSM's decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated September 3, 2015, affirming its benefit determination. 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 May 23, 2015, surgery?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form the Petitioner wrote:

I went to a preferred provider hospital to seek emergency medical treatment. Hospital could not provide treatment so I was sent to an on call doctor that is not in network. Requesting benefits to be paid as if doctor was in network. See attached information.

The Petitioner also included with his request an undated appeal letter he had earlier sent to BCBSM:

On Saturday May 23, 2015, I . . . was involved in an accident that required emergency medical attention. When the accident occurred I was rushed to the emergency room. . . . While there they stabilized me and informed my spouse that they had no surgeon [there] that could help me get the required medical procedure that I needed immediately.

The hospital then contacted one of their sister hospitals in [REDACTED] . . . I was sent by ambulance to this hospital where my spouse was told that's where my surgery would be performed. After arriving . . . and being admitted there for about 5½ hours, I was then informed that there was a mix-up and the surgeon that the hospital contacted wanted me at his office a few miles away to perform the surgery. The surgery was done then I was informed later that my doctor was not an "in network provider".

I am appealing to Blue Cross and Blue shield to pay this doctor his charges minus any deductibles and the 20% of my customary 80/20 plan that I am insured with through Blue Cross and Blue Shield for the following reasons:

- A) I went to an "in network" hospital to seek treatment, and no treatment was available to me since they had no Oral and Maxillofacial Surgeon.
- B) The hospital I was transported to accepted me for surgery but they didn't communicate well with the surgeon as to where surgery would be performed that I was required to have.
- C) [The surgeon] was the only Maxillofacial Surgeon that was available to perform the required treatment on this day because it was Memorial Day weekend. So in essence I had no other option available to me.
- D) I was heavily sedated and in no condition to ask or even think about whether my treatment was "in network "or not. I knew where I initially went for treatment was in fact an "in network" provider. After that I had no control of what my options were because I was sedated. The provider could not provide in this case. So my treatment required me to go elsewhere.

* * *

Also my treatment for this injury is ongoing. I have lost teeth that need to be replaced and I also need to have my bite corrected on the right side of my jaw because it now does not line up properly due to this injury. Once the jaw bone and nerve damage heals is when I am able to have these problems corrected (around October 2015).

I also request that Blue Cross and Blue Shield continue to pay [the surgeon] his charges in the future since he is the doctor most familiar with my injury and the care I have received from him and his staff has been exceptional. Thusly I am most comfortable with him.

Respondent's Argument

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

After review, I have confirmed that the claim for surgery services has been processed correctly, and that the \$848.35 payment that Blue Cross Blue Shield of Michigan (BCBSM) has already issued to you represents the maximum benefit available under your group's benefit policy. Payment of covered services is based on the approved amount. The balance of \$3,321.65 remains a matter to be resolved between you and [the surgeon's office].

You are covered under the *Community Blue Group Benefits Certificate LG*. Your PPO plan utilizes the Preferred Provider Organization network, which is designed to limit your out-of-pocket costs and provide the highest possible level of benefit compensation when you use physicians, hospitals and other health care specialists that are part of the network.

As indicated on page 100 of your health care coverage *Certificate*, you are covered for outpatient surgery services. Outpatient surgery services are payable at BCBSM's approved amount, which is defined on page 142 as, "The lower of the billed charge or our maximum payment level for the covered service."

Page 157 of your health care *Certificate* explains that non-participating providers are those that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full for services rendered. In this case, you received surgery services from a non-participating provider. BCBSM approved \$848.35 as payment. BCBSM sent payment for \$848.35 directly to you as payment for this claim. No additional payment can be made. Because [the surgeon's practice] is a non-participating provider, they may not accept the approved amount as payment in full. The balance amount of \$3,321.65 remains a matter to be resolved between you and the provider.

In your letter, you request to be approved for increased approved payment amounts for future services from [the surgeon]. As explained above, BCBSM pays the approved amount for covered services and cannot make additional payments beyond that. If you receive services from a non-participating provider in the future, you will be liable for any charges in excess of the BCBSM approved amount. To avoid unnecessary additional costs, I recommend using BCBSM in-network participating providers.

I do understand your frustration at receiving this substantial bill from the provider, and I also acknowledge that you did not have the opportunity to choose your provider on this occasion. However, BCBSM must administer benefits in accordance with the terms of your group's health care plan, and I am unable to make an exception on your behalf. As a Grievance and Appeals Coordinator, I reviewed your claim, your appeal, and your health care plan benefits for BCBSM.

Director's Review

Outpatient surgery is a covered benefit under the certificate (pp. 100-102). The certificate also says (p. 20):

- We pay our approved amount (see the definition in Section 7) for the services you receive that are covered in this certificate. . . .

"Approved amount" is defined in the certificate (p. 142) as

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

BCBSM determined that its maximum payment level for the Petitioner's oral surgery was \$848.35; because that amount was lower than the billed charge, it became BCBSM's approved amount.

BCBSM pays its approved amount to both participating and nonparticipating providers. However, a provider who has not signed a participation agreement with BCBSM (or with a Blue Cross/Blue Shield plan in another state) to accept the approved amount as payment in full may bill for the balance of the charges over the approved amount, as in this case. The certificate warns (p. 121):

If the out-of-network 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 the member. [Underlining added]

The Director accepts the Petitioner's assertion that he was suffering the aftereffects of his accident and was sedated and not able to make decisions about his care. However, BCBSM pays claims based on the participation status of the provider. There is nothing in the certificate or in the Insurance Code that requires BCBSM to pay more than its approved amount to a nonparticipating provider under any circumstance - even in an emergency or even if there are no participating providers available. If the Petitioner continues to seek treatment from the oral surgeon, he may again incur substantial out-of-pocket costs.

The Director concludes and finds that BCBSM correctly processed the claim for his surgery on May 23, 2015.

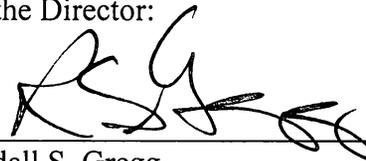
V. ORDER

The Director upholds BCBSM's final adverse determination of September 3, 2015.

This is a final decision of an administrative agency. 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 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