

**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. 153127-001-SF**

**State of Michigan, Plan Sponsor,**

**and**

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

**Respondents.**

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**Issued and entered**  
**this 2<sup>nd</sup> day of May 2016**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

Kathryn Kulju (Petitioner) was denied coverage for certain services related to her oral surgery by her health plan.

On April 7, 2016, ██████████, the Petitioner's authorized representative, filed a request with the Director of Insurance and Financial Services for an external review of that denial under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On April 14, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits as a dependent through a group health plan sponsored by the State of Michigan ("the plan" or "the State Health Plan"), a governmental self-funded plan as defined in 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 April 21, 2016.

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 medical benefits are described in the State Health Plan's *Your Benefit Guide* (the benefit guide). She also has dental benefits through Delta Dental Plan of Michigan.

On August 14, 2015, Petitioner had oral surgery that included the extraction of teeth #14, #15, and #18 under IV sedation and local anesthesia. The extractions and anesthesia were covered up to the maximum allowed by Delta Dental Plan of Michigan.

Once teeth #14 and #15 were removed, a fistula over those teeth required surgery which was performed by the Facial Surgery Institute: repair of the fistula (CPT code 30580); removal of bone for graft (CPT code 20900); and guided tissue regeneration (dental code D4266). When claims for these services were submitted to the plan, it eventually denied coverage, saying the treatment was dental in nature and therefore not a benefit.

The Petitioner appealed the denial through the plan's internal grievance process. At the conclusion of that process BCBSM issued a final adverse determination dated March 4, 2016, affirming the plan's decision. The Petitioner's now seeks a review of that final adverse determination from the Director.

## III. ISSUE

Did the plan correctly deny coverage for the Petitioner's August 14, 2015, oral surgery?

## IV. ANALYSIS

### Petitioner's Argument

The Petitioner's mother explained her grievance against BCBSM in a March 21, 2016 letter that was submitted with the request for an external, wherein she wrote:

Facial Surgery Institute obtained a pre-treatment estimate from Delta Dental . . . and told us to have [the Petitioner's] physician . . . make a referral to the Facial Institute so that the BCBSM charges for surgical repair of the hole in her sinus cavity with bone graft would be in network.<sup>1</sup>

\* \* \*

The initial BCBSM 9/4/15 EOB [*explanation of benefit payment*] shows coverage for the repair to the upper jaw fistula as out of network. Charges for "services" and removal of bone for graft required more or corrected information. Upon calling BCBSM, the referral from [the doctor's] office was received and the charges were in network & reprocessed, resulting in \$1,198.44 of the charges being paid, BCBSM EOB 9/18/15, for repair to

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<sup>1</sup> The Facial Surgery Institute is a nonparticipating provider with the State Health Plan.

upper jaw fistula. Our understanding was that the charges for "services" and removal of bone for graft were deemed not medically necessary.

\* \* \*

I also do not understand why a portion of the charges were covered by BCBSM and then withdrawn. The supporting information for medical necessity was submitted, yet the payment already made was reversed.

Please reconsider covering the repair to the sinus fistula as it was a medically necessary procedure. There was concern with the position of teeth in the sinus cavity. The teeth were calcifying with the adjacent teeth at risk.

### Plan's Argument

In its final adverse determination BCBSM told the Petitioner:

. . . After review, we determined that our payment determination is correct, dental services are not a benefit under your medical surgical health care plan. As a result, payment cannot be approved.

A medical consultant, board-certified D.D.S. in Oral and Maxillofacial Surgery reviewed your claim, your appeal, the dental records and letter of necessity . . . and your health care plan benefits for Blue Cross Blue Shield of Michigan (BCBSM). After review, our medical consultant determined that the management with primary closure of an iatrogenic sinus perforation is a dental procedure in the coding range of D7260 - D7294, and closure of sinus perforations are a covered benefit under the BCBSM Dental plan. The BCBSM medical policy "Dental Medical-Surgical Treatment" indicated that procedures covered under the BCBSM Dental plan are not covered under the BCBSM medical / surgical benefits unless indicated as covered under the member's benefits.

You are an eligible dependent covered under *The State Health Plan (The Benefit Guide)*. On page 31 of *The Benefit Guide*, it states that surgery is covered inpatient and outpatient, in the physician's office and in ambulatory surgical facilities. However, your surgical benefit does not cover dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists.

### Director's Review

The State Health Plan provides medical, not dental benefits. Coverage for dental-related services is very limited under the plan. The benefit guide (p. 10) explains that dental (oral) surgery is covered only when it is "performed on an inpatient basis." The benefit guide (p. 11) also covers dental treatment "to provide relief of pain and discomfort following an injury, as well as repair of those injuries." The Petitioner's treatment does not fall under either of these provisions: she was not treated on an inpatient basis nor did her need for dental treatment arise from an accidental injury. Under the terms of

Petitioner's coverage, here dental surgical services, although medically necessary, are not covered benefits.

BCBSM also referred to its medical policy, "Dental Medical-Surgical Treatment," which says:

[BCBSM] dental programs are intended to cover treatment of the teeth, supporting structures of the teeth and restoration of the dentition. As dental services, they are typically not covered as a medical-surgical benefit. However, dental services and surgeries which are "dental in nature" (i.e. restoration and extraction of teeth) may qualify for payment as a medical-surgical benefit if specific criteria are met.

Unfortunately, the Petitioner's dental surgery did not meet the criteria for coverage as a "medical-surgical" benefit.

For some reason BCBSM did not initially process the Petitioner's claims correctly in September 2015. But the Director concludes that the claims, as shown on the January 8, 2016, explanation of benefit payment statement, were reprocessed in accord with the terms of the benefit guide.

#### V. ORDER

The Director upholds the plan's March 4, 2016 final adverse determination.

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