

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. 154182-001

Blue Cross Blue Shield of Michigan,
Respondent.

Issued and entered
this 7th day of July 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was dissatisfied with the way her health insurer, Blue Cross Blue Shield of Michigan (BCBSM), processed a claim for ground ambulance transport.

On June 16, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on June 23, 2016.

The Petitioner receives health care benefits through an individual plan that is underwritten by 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 responded on June 28, 2016.

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 health care benefits are defined in BCBSM's *Blue Cross Premier Silver Benefits Certificate* (the certificate).

The Petitioner was transported by ambulance on December 20, 2015, while in Texas. The ambulance provider, Area Metropolitan Ambulance (AMA), does not participate with BCBSM or a local Blue Cross or Blue Shield plan in Texas. The charge for the transport was \$1,605.00. BCBSM's "approved amount" was \$579.66 and it paid that amount to AMA. This left the Petitioner responsible for the balance of \$1,025.34.

The Petitioner appealed the amount paid by BCBSM through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated May 11, 2016, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's ambulance transport?

IV. ANALYSIS

Petitioner's Position

On the request for external review form the Petitioner wrote:

My EOB [*explanation of benefit payments*] shows a zero balance which I had received and online as well, but within a few short days or maybe 2 weeks appeared a bill ... for \$1,605.00. I was confused and researched this and came up with my EOB amount you pay \$0.00? Then they in a two week period (turned ambulance ALS1) over to a collection agency.

Tried many attempts to tell them the appeal was in the process but they still sent the bill to another collection. I am seeking [*sic*] the EOB was misleading and caused a lot problems and phone calls and made me think it was covered.

BCBSM's Position

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

... After review, our decision is maintained and the balance of \$1,025.34 remains a matter between you and [the ambulance] provider.

* * *

I confirmed with the host plan, Blue Cross Blue Shield of Texas, that the provider ... you received ambulance services from is a nonparticipating provider. Since you received services from a non-participating provider,

you can be billed the difference (\$1,025.34) between the BCBS approved amount and provider's total charge amount.

Your appeal included a copy of your Explanation of Benefits statement for the services provided to you by Area Metropolitan Ambulance. During my review, I confirmed that the information reflected on the [EOB] statement is incorrect. Although the services were processed in-network, the provider did not participate with the host plan. As your online claim showed, and as explained above, the claim processed correctly and the provider can bill the difference between the charged amount and the BCBS allowed amount.

While I understand your concerns, regarding the services you received, BCBS must process claims as they are submitted and in accordance to your health care benefits.

Director's Review

Ambulance transport is a covered benefit under the certificate (p. 20) and there is no dispute that the Petitioner met the criteria for the service. The only dispute is over the amount paid for the service by BCBSM.

The certificate (p. 18) says that BCBSM pays its "approved amount" for covered services, including air ambulance transport. "Approved amount" is defined in the certificate (p. 151) as

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

In this case, BCBSM's maximum payment level for the ambulance service was \$579.66. Because this amount is lower than the billed charge from AMA, it became BCBSM's approved amount.

AMA is not a participating provider, i.e., it has not "signed a participation agreement with BCBSM to accept the approved amount as payment in full" (certificate, p. 171). Consequently, AMA may bill the Petitioner for the difference between BCBSM's approved amount and its charge. The certificate (p. 10) says:

Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount.

There is nothing in the certificate or in state law that requires BCBSM to pay more than its approved amount, even when the service is provided on an emergency basis, or if there was no participating provider available, or if the patient had no choice in which provider was used.

The Petitioner says that the explanation of benefit payments (EOB) shows that the amount she is required to pay for the ambulance transport was "\$0.00." This led her to believe she would not have any out-of-pocket expense for the transport. However, BCBSM acknowledged that the EOB was wrong. AMA is shown on the EOB as a participating provider when in fact it is a nonparticipating provider and therefore may bill the Petitioner for the difference between its charge and BCBSM's payment.

BCBSM paid its approved amount for the Petitioner's air ambulance transport. The Director concludes that BCBSM processed the ambulance claim in accord with the terms and conditions of the certificate and is not required to pay any additional amount.

V. ORDER

The Director upholds BCBSM's final adverse determination of May 11, 2016. BCBSM is not required to pay an additional amount for the Petitioner's December 20, 2015, ambulance services.

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:



Randall S. Gregg
Special Deputy Director