

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. 154708-001-SF

Kent County, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 16th day of August 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

████████████████████ (Petitioner) was denied coverage for emergency room care by her health plan. On July 20, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services seeking an external review of that denial under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On July 27, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a plan sponsored by Kent County (the plan), a self-funded local unit of government health plan as defined in section 1 of Act 495, MCL 550.1951. 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 it used to make the plan's final adverse determination. The Director received BCBSM's response on August 4, 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 presents an issue of contractual interpretation. 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 the *Member Handbook for Employees / Retirees of Kent County* (the handbook).

On October 2, 2015, the Petitioner was seen in the emergency room of Spectrum Butterworth Blodgett Hospital. The total charge for the visit was \$997.93. The plan covered an electrocardiogram that was part of the visit (CPT code 93005) and applied its approved amount for that test (\$28.50) to the Petitioner's in-network deductible. However, the plan disallowed the charge for emergency room visit (\$961.17), saying the Petitioner did not meet the criteria for emergency room care.

The Petitioner appealed the denial through the plan's internal grievance process. BCBSM held a managerial-level conference and at the conclusion of that process issued a final adverse determination dated April 28, 2016, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Was BCBSM correct when it denied the Petitioner's emergency room care?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form the Petitioner wrote:

My physician's P.A. [*physician assistant*] refused to treat my condition, suspected pinched spinal nerve, until I had an x-ray of my neck and back. She said it had to be done in the ER [*emergency room*].

The Petitioner explained the circumstances of her case in more detail in a July 15, 2016, letter sent with her external review request:

On Sept. 26th, 2015, I developed a back problem. I had gotten up in the early morning feeling fine. After a couple of hours I sat down and when I tried to get up I could not without considerable pain. I have an active lifestyle but had no idea what went wrong. The pain was throughout my entire back and my left arm was numb. All but one finger was also numb. The only way I could get any relief was to curl my left arm around my

head. Not being one to run to the doctor or hospital I tried across the counter drugs, stretches, etc. to get some relief. By Tuesday, Sept. 29th I called my doctor's office because my situation just kept getting worst [sic]. I was told I would have to wait weeks to see my doctor ... but her P.A. ... would be available at 12:30PM.

I went in immediately. [The] P.A. ... did a minimal exam. We talked about it being a pinched nerve. She said I would need an MRI before she could refer me to a specialist or for therapy. She said for her to order an MRI would take considerable time so she was referring me to ER. She said ER would get the MRI done immediately. I didn't understand this process at all. Having some medical background I thought it was a waste of the ER time and purpose when she or [my doctor] could just order the MRI. I left the office very upset that I was basically getting no treatment / referral that made sense to me.

Over the next 40 plus hours I made 3 calls to [my doctor's] office asking for help other than going to the ER. [The] P.A.'s office staff doubled checked with her and she was firm in her medical opinion that ER was my only option. That Friday morning, Oct. 2nd, I called the office again and asked that [my doctor] be consulted. [My doctor] agreed that I had to go to the ER. I was clearly told that the Doctor and P.A. were both in agreement that it was medically necessary that I go to Butterworth ER. AND now I'm being told that it could be a heart issue. This had NOT been previously discussed. Up until this time all that had been discussed was a nerve issue. OK, so now I have no other choice so I head to ER. And I wasn't buying the argument that it could be a heart issue at all. I got to ER and was checked in about 70 hours after my initial appointment with [the] P.A. ...

At the ER the doctor refused to do an MRI. He said they would only give an MRI to a patient in critical condition. He said this is Spectrum ER policy and [my doctor's] office should not have sent me.

BCBSM's Argument

In the final adverse determination, BCBSM's representative explained to the Petitioner:

... After review, the payment determination must be maintained.

You are covered under the Kent County health care plan. According to Page 28 of [the handbook]:

Emergency Room Care

You are covered for the treatment of accidental injuries or conditions that BCBS determines are medical emergencies. If you are not sure whether your condition (such as high fever, sharp, or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it's best to call your doctor or your doctor's after hours phone number.

In addition, Page 28 defines "medical emergency:"

A medical emergency is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

As explained above, emergency care requires prompt attention and is treated immediately. Your provider, Spectrum Butterworth Blodgett reported that the services were rendered 72 hours after the onset of your back pain. Because the services were rendered 72 hours after the onset of a sudden and serious illness, we are unable to approve payment.

* * *

To ensure all possible consideration, attempts we made to obtain your emergency room records from the provider, Spectrum Butterworth Blodgett Hospital. To date, we have not received the records.

BCBSM subsequently received and reviewed the emergency room medical records and issued a letter dated May 31, 2016, affirming the plan's initial decision:

An associate medical director, board-certified D.O. in Emergency Medicine reviewed your claim, your appeal, and your health care plan benefits for BCBSM. The physician determined that:

You went to the Emergency Room (ER) because of upper back and neck pain which had been present for 6-7 days after 'hitting the gym hard.' There was no reported injury, skin discoloration, bruising, swelling, fever, illness, loss of motor control. According to your health plan, the ER is for symptoms that come about suddenly with such severity that you are at risk for loss of life or serious bodily injury unless immediate medical attention is provided. This situation, as documented, does not meet criteria for emergent evaluation.

Director's Review

The plan covers care in the emergency room of a hospital for "medical emergencies." The handbook (p. 28) says that a medical emergency "is a condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless treated immediately." Section 3406k of the Insurance Code, MCL 500.3406k, also says:

(1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for emergency health services shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization not being given by the insurer before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

This case was not assigned to an independent review organization for a recommendation pursuant to section 11 of the Patient's Right to Independent Review Act, MCL 550.1911, because the Director determined that a prudent layperson would not expect that the absence of medical attention in the emergency room would have resulted in serious jeopardy to the Petitioner's health.

In this case the Petitioner says she developed back pain on September 26, 2015. She contacted her physician's office three days later (September 29, 2015) and was under professional care from that date. She was not seen in the emergency room until October 2, 2015, six days after the onset of symptoms. From the Petitioner's account, she was sent to the emergency room solely or chiefly for magnetic resonance imaging (MRI), a procedure commonly performed in a non-emergency setting.

The Petitioner's visit to the emergency room was 70 hours after she had gone to her physician's office, which does not indicate that she needed immediate care. Also, the hospital physician's report did not describe her condition as an emergent and the hospital physician further said there was "no indication for any emergent MRI in the emergency department" nor did the physician "believe that x-rays or a CT scan would be helpful." There is nothing in the record from which the Director could conclude that the emergency room visit on October 2, 2015, was occasioned by a medical emergency.

The Director concludes that the plan's denial of the Petitioner's emergency room visit on October 2, 2015, was consistent with the provisions of the handbook.

V. ORDER

The Director upholds the plan's 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 sixty 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:



Randall S. Gregg
Special Deputy Director