

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

Blue Cross Blue Shield of Michigan
Petitioner

v

Case No. 11-833-BC

Break-Thru Medical, LLC
Respondent

Issued and entered
this 21st day of February 2013
by R. Kevin Clinton
Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan (BCBSM) of one of its participating providers, Break-Thru Medical, LLC, a supplier of durable medical equipment (DME). BCBSM audited the records of 138 patients who had received DME through Break-Thru Medical during the period May 1, 2007 through April 30, 2008.

Based on its audit findings, BCBSM concluded that the provider had failed to properly document claims it had submitted to BCBSM. Consequently, BCBSM sought recovery from Break-Thru Medical of \$99,078.78. Break-Thru Medical challenged BCBSM's conclusions through BCBSM's internal appeal process and BCBSM subsequently reduced its proposed recovery to \$49,277.92 (by the time of the hearing, BCBSM stipulated that the alleged overpayments totaled \$43,869.13).

Break-Thru Medical continued to dispute BCBSM's findings. A Review and Determination proceeding was held by the Commissioner's designee.¹ The review and determination considered in detail the audit findings for five of the 138 patients who were the subjects of BCBSM's audit.

The analysis in the Review and Determination was based largely on a finding that the documentation requirements applicable to the audits were established in BCBSM's 2006 provider manual and not the more stringent documentation requirements published in a sub-

1. See MCL 550.1404.

sequent edition of the manual issued in April 2008. The reduced recovery amount was calculated by the Commissioner's designee by applying the more stringent rules only to the DME claims occurring in the latter part of the audit (i.e., after April 2008).

Based on this analysis, the Commissioner's designee concluded that BCBSM should only be permitted to recover 12.8 percent of the amount it sought. The Commissioner's designee extrapolated her findings regarding the five patients to the entire group of 138 patients and reduced the amount BCBSM should be permitted to recover to \$6,307.57 (12.8 percent of \$49,277.92).

The Commissioner's designee also concluded that BCBSM had violated section 402(1)(f) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(f) by failing to make a good faith attempt at a prompt, fair and equitable settlement of denied claims.

The Review and Determination conclusions were appealed to the Commissioner by BCBSM. A contested case hearing was held on July 25, 2012. Prior to the hearing, the parties submitted two joint statements of facts. At the hearing, the parties presented 17 joint exhibits and the testimony of four witnesses.

The administrative law judge issued a Proposal for Decision (PFD) on November 30, 2012 which accepted the analysis of the Commissioner's designee, although the administrative law judge did modify the actual calculation of the refund from \$6,307.57 to \$6,083.19. (See PFD, p. 12, paragraph 36.) Neither party filed exceptions to the PFD.

In reviewing the hearing record, the Commissioner finds that there is insufficient evidence to support both the recovery amount calculated by the Commissioner's designee (\$6,307.57) and the modification recommended by the administrative law judge in the PFD (\$6,083.19). Consequently, BCBSM's permissible recovery should be \$5,615.25, as described in paragraphs 32-35 of the PFD.

In the PFD, the administrative law judge recommended that the Commissioner make the following findings:

- (1) BCBSM did not violate section 402(1)(f) of Act 350, and
- (2) BCBSM should be permitted to recover a refund of \$6,083.19 from Break-Thru Medical.

II. FINDINGS OF FACT

The findings of fact in the PFD, except as noted below, are supported by the hearing record. The Commissioner adopts and incorporates those findings of fact in this order, excepting finding of fact #36. The PFD is attached.

III. CONCLUSIONS OF LAW

The Commissioner finds that the conclusions of law stated in the PFD are properly grounded in the facts of this case and are soundly reasoned. Those findings are adopted except as they pertain to the amount of BCBSM's permissible recovery.

IV. ORDER

It is ordered that:

1. BCBSM may recover \$5,615.25 from Break-Thru Medical, LLC.
2. BCBSM did not violate section 402(1)(f) of Act 350.



R. Kevin Clinton
Commissioner

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:

Docket No. 11-000783-OFIR

Blue Cross Blue Shield of Michigan,
Petitioner

Agency No. 11-833-BC

Agency: Office of Financial & Insurance
Regulation

v

Break-Thru Medical, L.L.C.,
Respondent

Case Type: Appeal
Subscriber/Provider

Filing Type: Appeal

Issued and entered
this 30th day of November 2012
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

Appearances: Bryant D. Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Petitioner (hereafter "BCBSM"). Gregory M. Nowakowski and Theresamarie Mantese, Attorneys at Law, appeared on behalf of Break Thru Medical, LLC, Respondent (hereafter "BTM").¹

This proceeding under the Nonprofit Health Care Corporation Act, 1980 PA 350, as amended, MCL 550.1101 *et seq.* (hereafter "Nonprofit Act") commenced in the Michigan Administrative Hearing System with the issuance of a notice of hearing on August 5, 2011, which scheduled a contested case hearing for September 6, 2011. The notice of hearing was issued pursuant to a request for hearing received on July 26, 2011, and an Order Referring Complaint for Hearing and Order to Respond by Special Deputy Commissioner of the Office of Financial and Insurance Regulation, dated July 22, 2011.

The Complaint references allegations set forth in BCBSM's Petition for Contested Case Hearing, dated July 15, 2011, by which it seeks reversal of the Review and Determination issued by the Commissioner's Designee on May 17, 2011, that

¹ Note: The parties agreed at hearing to correct the party designation to show BCBSM, which filed the petition for contested case hearing, as Petitioner, and BTM as Respondent. [Tr, p 5].

concluded it had violated Section 402(1)(f) of the Nonprofit Act and reduced its refund request.

On August 18, 2011, the undersigned issued an Order Converting Hearing Date to Telephone Prehearing Conference, at the parties' request.

On August 24, 2011, BTM filed a Response to the Petition for Contested Case Hearing. On September 6, 2011, a telephone prehearing conference was held as scheduled with the parties' attorneys.

On September 12, 2011, the undersigned issued an Order Following Prehearing Conference, which scheduled the contested case hearing for November 10, 2011. On October 21, 2011, the undersigned issued an Order Granting Adjournment, rescheduling the contested case hearing to January 10, 2012.

On November 22, 2011, BTM filed a Motion for Summary Disposition and Brief Supporting Summary Disposition Affirming the Review and Determination. On November 23, 2011, the undersigned issued an Order Adjourning Hearing and Scheduling Motion Hearing. On November 23, 2011, BCBSM filed a response to the Motion for Summary Disposition. On November 29, 2011, BTM filed a Reply to the Response to Summary Disposition. On December 16, 2011, BTM filed a notice concerning filing dates for witness and exhibit lists.

On December 22, 2011, BTM filed a Joint Statement of Facts. On January 10, 2012, a motion hearing was held as scheduled. On January 19, 2012, the undersigned issued an Order Denying Motion for Summary Disposition and Scheduling Hearing, which rescheduled the contested case hearing to March 27, 2012.

On March 9, 2012, BTM filed its witness and exhibit lists. On March 19, 2012, BCBSM filed its witness and exhibit lists. On March 22, 2012, the undersigned issued an Order Granting Adjournment based on a stipulation of the parties, which rescheduled the contested case hearing to May 15, 2012.

On May 9, 2012, BTM filed a Second Joint Statement of Facts and Joint Exhibit Binder. On May 15, 2012, the undersigned issued an Order Granting Adjournment based on a stipulation of the parties, rescheduling the contested case hearing to June 25, 2012. On May 30, 2012, the undersigned issued an Order Granting Adjournment based on a stipulation of the parties, rescheduling the contested case hearing to July 25, 2012.

On July 25, 2012, the contested case hearing was held as scheduled. BCBSM called David Keener, R.Ph. as a witness. BTM called Julie Chawla, James Kinsman and Kristi Placencia as witnesses. The parties offered the following joint exhibits that were admitted into evidence:

1. Joint Exhibit No. 1 is a copy of BCBSM's December 2006 provider manual chapter for "Durable Medical Equipment: Billing and Reimbursement".
2. Joint Exhibit No. 2 is a copy of BCBSM's December 2008 provider manual chapter for "Durable Medical Equipment" Billing and Reimbursement".
3. Joint Exhibit No. 3 is a copy of a BCBSM article in *The Record*, "Remember to document duration of need for DME items", dated January 2006.
4. Joint Exhibit No. 4 is a copy of a BCBSM article in *The Record*, "Conversion to consolidated computer system begins soon", dated April 2008.
5. Joint Exhibit No. 5 is a copy of BCBSM's "Durable Medical Equipment/Prosthetic and Orthotic Supplier Provider Participation Agreement".
6. Joint Exhibit No. 6 is a copy of medical records for patient S.B. (initials used for confidentiality purposes).
7. Joint Exhibit No. 7 is a copy of medical records for patient C.C.
8. Joint Exhibit No. 8 is a copy of medical records for patient A.C.
9. Joint Exhibit No. 9 is a copy of medical records for patient M.G.
10. Joint Exhibit No. 10 is a copy of medical records for patient S.Br.
11. Joint Exhibit No. 11 is a copy of the Curriculum Vitae of Julie A. Chawla, Certification Consultants, Inc.
12. Joint Exhibit No. 12 is a copy of the BCBSM's initial recovery letter, dated July 25, 2008.
13. Joint Exhibit No. 13 is a copy of the BCBSM's Professional Utilization Review Reports, dated July 25, 2008.
14. Joint Exhibit No. 14 is a copy of the BCBSM's reconsideration review letter, dated November 14, 2008.
15. Joint Exhibit No. 15 is a copy of BCBSM's Professional Utilization Review Reports, dated November 14, 2008.
16. Joint Exhibit No. 16 is a copy of the Managerial Level Conference results letter from BCBSM, dated April 30, 2009.

17. Joint Exhibit No. 17 is a copy of BCBSM's Patient Credit Refund Report, dated April 30, 2009.

At the close of the hearing, the record was held open for written closing arguments. On August 17, 2012, BTM filed the original transcript from the January 10, 2012 motion hearing (hereafter "Motion Tr") and the July 25, 2012 contested case hearing (hereafter "Tr").

On September 20, 2012, BCBSM filed a Post Hearing Brief. On September 21, 2012, BTM filed Proposed Findings of Fact and Conclusions of Law. On October 4, 2012, BCBSM filed a Reply to [BTM's] Post Hearing Brief. On October 5, 2012, BTM filed a Reply to [BCBSM's] Post Hearing Brief. The record closed as of October 5, 2012.

ISSUES AND APPLICABLE LAW

The issues presented are:

- 1) Whether the established facts evidence a violation by BCBSM of Sections 402(1)(a-g) & (l-m) of the Nonprofit Act, *supra*.

- 2) Whether BCBSM's request for refund should be reduced from \$49,277.92 to \$6,307.57, as set forth in the Review and Determination.

The Complaint issued with the Order Referring Complaint for Hearing and Order to Respond, dated July 22, 2011, cites Section 402(1)(a-g) & (l-m) of the Nonprofit Act as the applicable law. The Review and Determination found a violation of Section 402(1)(f). These statutory provisions state as follows:

Sec. 402. (1) A health care corporation shall not do any of the following:

- (a) Misrepresent pertinent facts or certificate provisions relating to coverage.

- (b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

- (c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

- (d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

* * *

(l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate. MCL 550.1402(1)(a-g) & (l-m).

Respondent requested a contested case hearing in accordance with Section 404(6) of the Nonprofit Act, *supra*, which states:

Sec. 404. (6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act. MCL 550.1404(6).

The administrative rules on Procedures for Informal Managerial-Level Conferences and Review by Commissioner of Insurance, 1986 AACRS, R 550.101 *et seq.*, state in pertinent part:

Rule 102. (1) A person who believes that a health care corporation has wrongfully refused his or her claim in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, or has otherwise violated section 402 or sections 403 of Act No. 350 of the Public Acts of 1980, as amended, shall be entitled to a private informal managerial-level conference with the health care corporation.

* * *

(4) At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws. 1986 AACCS, R550.102(1)&(4). (Emphasis supplied).

Rule 103. (1) Within 10 days of the conclusion of the private informal managerial-level conference, the health care corporation shall provide all of the following information to the grievant:

- (a) The proposed resolution of the health care corporation.
- (b) The facts, with supporting documentation, upon which the proposed resolution is based.
- (c) The specific section or sections of the law, certificate, contract, or other written policy or document upon which the proposed resolution is based.
- (d) A statement explaining the person's right to appeal the matter to the commissioner within 120 days after receipt of the health care corporation's written statement provided in subrule (2) of this rule.
- (e) A statement describing the status of the claim involved. 1986 AACCS, R 550.103(1).

Rule 104. (2) The grievant may appeal to the commissioner within 120 days of the date the person received the health care corporations' proposed resolution . . . 1986 AACCS, R 550.104(2).

Rule 105. (3) The commissioner or commissioner's designee shall conduct meetings in a manner which allows the disputing parties to present relevant information to substantiate their positions. 1986 AACCS, R 559.105(3). (Emphasis supplied).

Rule 107.(3) The commissioner or the commissioner's designee shall notify the health care corporation and the grievant of the right to request a contested case hearing if a

party disagrees with the written decision. 1986 AACS, R 550.107(3). (Emphasis supplied).

Rule 108. (1) If the decision by the commissioner or the commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.

(2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of the claim. 1986 AACS, R 550.108.

FINDINGS OF FACT

Based on the entire record in this matter, including the testimony and admitted exhibits, the following findings of fact are established:

1. Break-Thru Medical, LLC (BTM) is a durable medical equipment company located in Mount Clemens, Michigan. [Exh. 12; Tr, p 8].
2. BCBSM conducted a post-payment audit of BTM's payment claims for dates of services from May 1, 2007 through April 30, 2008, for 138 patient files. [Joint Statement of Facts; Motion Tr, p 12; Tr, pp 40, 77; Exh. 15, p 00331].
3. BCBSM considered the post-payment audit at issue to be strictly a "compliance audit" rather than a "medical necessity audit." David Keener, R.Ph., the utilization review manager for BCBSM's durable medical equipment audits, credibly testified that in a compliance audit BCBSM reviews the records of a provider, including physician orders, against its documentation guidelines. [Tr, p 12].
4. The provider manual provisions applicable to the denied claims in the audit are contained in BCBSM's published manuals for December 2006, and April 2008. [Joint Statement of Facts; Exh. 1 & 2].
5. The December 2006 provider manual likely applied to BTM's claims for the period of May 1, 2007 through March 31, 2008 (11 months).

6. The April 2008 provider manual likely applied to BTM's claims for the period of April 1, 2008 through April 30, 2008 (1 month).
7. The provider manual required a provider such as BTM to make documentation available to BCBSM's auditors at the time of an audit. The manual stated that "[a]ll documentation must identify the patient and describe the services you provided and billed. This documentation must be made available to us during an audit. . . . If we don't see proper and adequate documentation during an audit, we can deny items or services and ask you for a refund." [Exh. 1, pp 3-4].
8. In its audit findings, BCBSM primarily denied BTM's claims based on the denial codes "Incomplete Order" and "NO" or "No Order," on the basis that the physician did not itemize each component part of the durable medical equipment being requested in the order. [Exh. 13; Tr, p 13].
9. BCBSM now concedes BTM's delivery charges as they relate to the audit. [Joint Statement of Facts; Exh. 16 & 17; Tr, p 11].
10. The remaining outstanding alleged overpayment is \$43,869.13, which does not include delivery charges. [Joint Statement of Facts; Tr, p 42].
11. BTM does not challenge the statistical sampling or extrapolation performed by BCBSM in its audit. [Joint Statement of Facts].
12. BCBSM's provider manual, effective December 29, 2006, required that prescriptions for replacement supplies must specify the supplies needed and the frequency of use, replacement or consumption. It stated in pertinent part:

"Prescription

The prescription must include the following information:

* * *

- Patient's name
- Physician's name, address, phone number and original signature
- Prescription date
- Starting date of service
- Diagnosis or reason for need
- Description and quantity of items or services ordered
- Duration of need or length of time an item will be required

"A prescription for replacement supplies must also specify:

- The supplies needed
- The frequency of use, replacement or consumption

Note: We cannot accept 'PRN' or 'as needed' as estimates for supply replacement, use or consumption." [Exh. 1, p 4]. (Emphasis supplied).

13. The above-quoted language in the December 2006 manual likely shows an intended distinction between an initial prescription, such as for the initial outfitting of a CPAP machine or nebulizer, and a prescription order for replacement supplies, in which the prescription must show frequency of use, replacement and consumption. [Tr, pp 92-93].
14. The record does not show that BTM improperly filled prescriptions during the audit period, up until the last month audited, being April 2008, other than was found in the Review and Determination. BTM's part-owner, Kristi Placencia, offered credible and reasonable explanations regarding the timing of the prescriptions in question, the correction of prescription dates and other specific discrepancies noted in the audit. [Tr, pp 80-87].
15. It is more likely than not that for the first 11 months of the audit period when a physician ordered a CPAP machine, the prescription was intended to include all the components necessary to use the CPAP machine. Otherwise, as BTM points out, it would be just a useless mask. The same logic would apply to supplying a cup with a nebulizer device. [Motion Tr, p 16; Tr, pp 70-71].
16. Ms. Placencia credibly testified that she understood the phrase "supplies needed" in the provider manual to include all the equipment that is required to make the durable medical equipment functional. She credibly testified that "CPAP machines are expensive, and for us to just provide a CPAP machine with nothing for the customer to use it with, that would really just be a waste of money." [Tr, pp 79, 98].
17. BTM's employee, James Kinsman, credibly showed at hearing that the CPAP unit typically comes from the manufacturer or distributor with supply components that make it functional: the heated humidifier, tubing to attach the mask and headgear. [Tr, pp 67-68].
18. Mr. Kinsman credibly acknowledged that that some components could come from another provider other than BTM, but also credibly testified that it is "highly unlikely" for one durable medical equipment company to order the CPAP machine and for another company to order just the tubing. [Tr, pp 71-72].

19. Mr. Kinsman acknowledged that it is possible that patients may already have certain components that would be regularly included originally with a CPAP machine (such as from a prior prescription). [Tr, p 73]. This fact alone would not appear to prove that BTM failed to comply with the terms of the December 2006 provider manual when dispensing durable medical equipment based on initial prescriptions supplied to it.
20. BCBSM's witness, Mr. Keener, acknowledged that a CPAP machine needs a mask, tubing, headgear and chin straps for use, and that a nebulizer needs a cup to disperse medicine. However, Mr. Keener testified that BCBSM cannot determine if it is the intent of a physician for a patient to get these accessories from BTM without the accessories being on the order. [Tr, pp 36-37].
21. It is more likely than not that prior to April 2008, BCBSM's policy effectively presumed that the intent of a physician ordering durable medical equipment such as a CPAP machine for a patient was that the patient would get the supplies necessary to make durable medical equipment functional, and that the practice in the industry for durable medical equipment at the time was to include necessary components before the equipment was provided to the patient. [Tr, p 79].
22. In his testimony, Mr. Keener drew a distinction based on billing for items separately, in which there must be a description of each item and quantity. This did not address the question of component supplies when devices such as a CPAP machine or nebulizer are ordered, however. He testified:

"And the way I usually explain this is, if you – say you could bill us for a car, now all the elements of a car that make it run are expected to be in there, the motor, the tires, etcetera. Now, would you need an order for the tires and the motor; no, unless you were billing us for the tires separately. If you're billing us for a tire, you would have to have an order for the car and an order for the tires, even though the tires are necessary to make the car run. If you're billing us separately, our manual states you need a description of the item, the quantity, etcetera." [Tr, p 38 (Emphasis supplied)].
23. BCBSM's provider manual, effective April 1, 2008, states in pertinent part (with the underlined portion being newly added language):

"Certificates of Medical Necessity, Physician Orders, and Prescriptions

"The CMN, physician order and prescription must include the following information:

- Patient's name
- Physician's name, address, phone number and original signature
- Prescription date
- Starting date of service
- Diagnosis or reason for need
- Description and quantity of items or services ordered
- Duration of need or length of time an item will be required

"In accordance with Medicare requirements, durable medical equipment items and supplies must be individually specified by the physician on prescriptions, physician orders or CMNs. A listing of possible items to be dispensed with a physician's signature is no longer accepted. For example, an order listing a glucometer, batteries, test strips, lancets, calibration solution and a spring-powered device for lancets needs to be more specific.

"If preprinted order forms are used, the prescriber must select the exact item and indicate the quantity of each item being prescribed.

"For those supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity to be used, frequency of change and duration of need. These orders must also include all options or additional features that will be billed separately or will require an upgraded code. The upgraded code needs to be descriptive.

"A prescription for replacement supplies must also specify:

- The supplies needed
- The frequency of use, replacement or consumption

Note: We cannot accept 'PRN' or 'as needed' as estimates for supply replacement, use or consumption." [Exh. 2, p 5 (Emphasis supplied); Tr, 35-36].

24. In April 2008, BCBSM published an article in its provider newsletter, *The Record* entitled, "DME [Durable medical equipment] orders now need to be more specific". The article stated that "In accordance with Medicare requirements, durable medical equipment items and supplies must now be individually specified by the physician on prescriptions or certificates of medical necessity. Orders that simply list all of the possible items to be dispensed and include the physician's signature will no longer be accepted." [Exh. 4 (Emphasis supplied)].
25. The April 2008 article in *The Record* likely refers to an actual change in BCBSM's policy, effective April 1, 2008, that pertained to both initial prescriptions and replacement supplies, in which each specific item of equipment were then required to be individually itemized. [Exh. 4; Tr, pp 55, 79].

26. After the April 2008 article, BTM likely immediately changed its own policy to individually specify dispensed items on the prescription or order forms, per Ms. Placencia's credible testimony. [Tr, pp 90-92].
27. It is likely that BCBSM changed its provider manual requirements in April 2008 to correspond with a change in Medicare requirements, in which orders were then required to be more detailed. [Tr, pp 51-52].
28. On July 25, 2008, BCBSM sent a letter to BTM with the results of the June 30, 2008 audit of BTM's records on durable medical equipment and supplies. At that time, BCBSM requested a refund of \$99,076.78 as overpayment. [Exh. 12].
29. On November 14, 2008, BCBSM sent a letter to BTM, indicating that based on a Reconsideration Review, the requested refund amount was reduced from \$99,076.78 to \$66,604.04. [Exh. 14].
30. On March 25, 2009, the parties had an informal managerial conference, at which time BCBSM reduced its requested refund amount to \$49,277.92. [Rev. and Det., p 2].
31. On March 17, 2010, the Commissioner's Designee conducted a meeting of the parties at the Office of Financial and Insurance Regulation. [Rev. and Det., p 1].
32. On May 17, 2011, the Commissioner's Designee issued a Review and Determination, which found that BCBSM had failed to make a good faith attempt at a prompt, fair and equitable settlement on five sample patient files, representing \$2,010.19 or 87.2% of the total requested refund.
33. The Commissioner's Designee indicated that \$210.00 of the \$2,010.19 amount pertains to delivery charges. [Rev. and Det., p 12]. BCBSM has conceded that delivery charges are no longer at issue. [Tr, p 11].
34. The Commissioner's Designee applied the 87.2% to the \$49,277.92 figure then at issue and reduced the total requested refund to \$6,307.57. [Rev. and Det., p 13].
35. The 87.2% should be applied to the \$43,869.13 amount now at issue, meaning that the remaining 12.8% amount would be \$5,615.25.
36. The requested refund amount should account for the one month of the audit period, April 2008, in which there was a change in provider manual requirements. Accordingly, the \$5,615.25 figure should be increased by 1/12 to \$6,083.19.

CONCLUSIONS OF LAW

As the complaining or appealing party, BCBSM has the burden of proof to show grounds for reversal or modification of the decision in the Review and Determination. See, *American Way Service Corporation v Commissioner of Insurance*, 113 Mich App 423; 317 NW2d 870 (1982).

Based on the above findings of fact, it is concluded that BCBSM has met its burden of proof in part, to show that the total refund due should be increased by 1/12, as found above. BCBSM has not shown that the balance of the refund amount is properly requested from BTM, however.

Further, based on the above findings of fact, it is concluded that a preponderance of evidence does not show that BCBSM violated Section 402(1)(f) of the Nonprofit Act by failing "to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear" as found in the Review and Determination. Rather, the record evidence shows that it is more likely than not that BCBSM attempted in good faith to apply the terms of the applicable provider manual throughout the audit, but reached a different interpretation of the terms of the manual than was found above and by the Commissioner's Designee.

The record evidence shows that payment had already been made to BTM, and the audit findings sought a refund. In that context, BCBSM did not fail to attempt in good faith to make a prompt, fair and equitable settlement. See the Commissioner's Final Decision in *Internal Medicine Associates of Mt. Clemens v Blue Cross Blue Shield of Michigan*, Docket No. 2010-132, Case No. 10-763-BC, issued on June 29, 2011.

It is further concluded that the established facts do not show a violation of the other subsections cited as applicable in the Complaint, being Section 402(1)(a-e, g) & (l-m).

PROPOSED DECISION

The undersigned Administrative Law Judge proposes that the Commissioner issue a Final Decision, which adopts the above findings of fact and conclusions of law.

It is proposed that the Final Decision reverse the Review and Determination's conclusion that BCBSM violated Section 402(1)(f) of the Nonprofit Act.

It is further proposed that the Final Decision modify the requested refund amount to \$6,083.19.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Office of Financial and Insurance Regulation, Division of Insurance, Attention: Dawn Kobus,

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P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after exceptions are filed.



Lauren G. Van Steel
Administrative Law Judge