

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

Internal Medicine Associates of Mt. Clemens
and
Jerome Finkel, M.D.,
Petitioners

Case No. 10-763-BC
Docket No. 2010-132

v

Blue Cross Blue Shield of Michigan,
Respondent

Issued and entered
this 29th day of June 2011
by R. Kevin Clinton
Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns a 2008 audit by Blue Cross Blue Shield of Michigan of one of its participating providers, Internal Medicine Associates of Mt. Clemens (IMA). Based on its audit findings, BCBSM concluded it had erroneously paid the provider for several medical tests known as “cardiac computed tomography angiography” or “CCTA.” BCBSM demanded repayment of \$8,738.80 from the provider.

The provider disputed BCBSM’s audit findings. A Review and Determination proceeding was held by the Commissioner’s designee¹ who concluded that BCBSM had violated section 402(1)(e) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(e). The Commissioner’s designee also concluded that BCBSM was not entitled to recover the funds in question.

The decision was appealed to the Commissioner by BCBSM. A contested case hearing was held and a proposal for decision (PFD) was issued on February 19, 2011. The PFD reached the same conclusions as the Review and Determination. Neither party has filed ex-

1. See section 404 of the Nonprofit Health Care Corporation Reform Act of 1980, MCL 550.1404.

ceptions to the PFD. It now remains for the Commissioner to adopt or reject the recommendations found in the PFD.

II. FINDINGS OF FACT

A. FINDINGS OF FACT FROM PFD

The factual findings in the PFD, other than those identified below, are in accordance with the preponderance of the evidence and are adopted. The findings of fact below are not adopted.

1. Paragraph 19 is not adopted because it is merely a restatement of the position of one of the parties and is, therefore, not a finding of fact.

2. The first two sentences of paragraph 26 are not adopted because they are speculative in nature.

3. Paragraph 31 is not adopted because it simply restates a portion of the Review and Determination which is already a part of the record (Respondent Exhibit 11).

B. ADDITIONAL FINDINGS OF FACT

Based upon the record in this matter, the Commissioner makes the following findings of fact in addition to those adopted from the PFD. To the extent any of the findings of fact adopted from the PFD are inconsistent with the findings below, the PFD findings are superseded. The Commissioner finds that:

1. BCBSM made timely payment to IMA of the claims for CCTA which are the subject of this hearing.

2. The BCBSM audit was started and concluded in a timely manner consistent with the requirement of the Provider Agreement which limits actions to initiate recovery of overpayments to two years from the date of payment, except in instances of fraud.

3. There was no evidence of fraud in the presentation of the claims in question.

III. ANALYSIS

The details of the claims at issue are found in BCBSM's Patient Refund Credit Report (part of Petitioner Exhibit 8). BCBSM audited 44 claims for CCTA testing (identified as procedure "0144T" in Exhibit 8). The claims were all paid by BCBSM within two weeks of the date of service. Payment for each service ranged from \$29.76 to \$350.00 with the typical charge being \$200.00. The earliest charge identified in the audit was for a CCTA test on January 10, 2008; the latest test occurred on July 17, 2008.

BCBSM sought to recover a total of \$8,738.80 from IMA. In a September 4, 2008 letter to IMA (part of Petitioner Exhibit 8), BCBSM explained the reason it felt repayment was required:

[BCBSM] recently discovered that CCTA services reported were billed and paid incorrectly to non-participating consortium providers. We are writing to recover these overpayments. The enclosed listing identifies each incorrect payment for member services rendered. Please see enclosed *Record* article (July 2008) regarding BCBSM reimbursement policy for Cardiac Computed Tomography Angiography (CCTA).

Prior to launching the coronary tomography angiography initiative program in July 2007, [BCBSM] did not reimburse for these services. To be included in the CCTA program participants must meet application criteria. The current application process closed July 31, 2008. After this date, new applications will be accepted annually.

The relationship between BCBSM and IMA is governed by a "Physician and Professional Provider Participation Agreement" (Respondent Exhibit No. 2) which is a standard contract that BCBSM requires of all its providers. Addendum H of the Agreement contains an "audit and recovery" provision which includes this clause:

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary....

In reviewing the various communications between BCBSM and IMA, it is clear that the audit dispute concerns benefit criteria rather than issues of medical necessity (BCBSM has not disputed the medical necessity of the CCTA tests). The term "applicable benefit criteria" is not defined in the Agreement. There is no discussion in the PFD or Review and De-

termination concerning this term. It is necessary, therefore, to establish what is meant by “applicable benefit criteria” and how that term applies to this dispute.

Each party has offered its own argument as to the standards that should be used to determine whether the disputed claims should be covered. According to BCBSM, the appropriate standard is described in *The Record*, a newsletter distributed to BCBSM providers. In contrast, IMA’s witness, Dr. Finkel, testified that he relied on BCBSM’s web site for providers, “webDENIS” to determine whether IMA was qualified to bill for the CCTA procedures it performed. Dr. Finkel testified, without contradiction, that when the claims were submitted, BCBSM paid the claims. This is certainly correct since it is these same claims which BCBSM has now attempted to recoup.

Both *The Record* and webDENIS can be viewed as “applicable benefit criteria.” Both are used to govern when a particular benefit will be paid.

If *The Record* was the sole source of such information, it would be clear to providers what the coverage limits were for this procedure. However, Dr. Finkel learned from some of his patients that they were able to submit claims directly to BCBSM and be reimbursed for the procedure. Dr. Finkel then called BCBSM to determine if the claims procedures for CCTA tests had been changed. The individual he spoke to was unable to give him the answer to his inquiry but did refer him to webDENIS.

When Dr. Finkel checked the coverage available for the procedure through the webDENIS system, he learned that the system did indicate coverage would be provided. His practice group then began to submit CCTA claims to BCBSM and, as noted above, the claims were paid.

IV. CONCLUSIONS OF LAW

A. CONCLUSIONS OF LAW FROM PFD

For the reasons noted below, the following conclusions of law stated in the PFD are not adopted.

1. “[BCBSM] has not shown that the refund request...constitutes mistaken payments to Petitioner.”

The issue to be resolved is whether the claims in question should be recovered because they did not meet BCBSM's "applicable benefit criteria" not whether a mistake had been made. In *Kilpatrick, et al v BCBSM*, 04-394-BC, (2005), BCBSM, after a provider audit, sought to recover claims payments from several providers for overpayments made as a result of an error in BCBSM's computer system. The Commissioner ruled that BCBSM could not recover the payments because the providers had reasonably relied, to their detriment, on the claims being correctly paid.

In the present case, the Commissioner finds that *The Record* and BCBSM's webDENIS system are both legitimate sources to be utilized by providers to determine if coverage is available. Both are the creation of BCBSM and both are controlled and maintained by BCBSM. The hearing record does not establish that one source is superior to the other in determining what services are payable by BCBSM. They are both, therefore, sources for determining BCBSM's "applicable benefit criteria." Under the standards in *The Record*, the claims payments should not have been made. Under the webDENIS system, the claims were paid. BCBSM is responsible for both sources of information.

Issues of *The Record* show an evolving policy regarding CCTA, from a very restrictive policy reimbursing only hospitals to a broader acceptance of claims from providers and hospitals within an expanding provider consortium. It would be perfectly reasonable for IMA to conclude, based on webDENIS information, that CCTA claims were being accepted from a still broader group of providers.

2. Respondent has failed to "affirm or deny coverage of a claim within a reasonable time after a claim has been received" contrary to section 402(1)(e) of [Act 350]."

BCBSM did not fail to affirm the claims in question – the claims were paid within two weeks of the service being provided. The audit that followed was executed within the time frames permitted for claims payment audits set out in the Provider Agreement. There is no evidence in the record which would support a conclusion that BCBSM did not "affirm or deny coverage of a claim within a reasonable time after a claim has been received." As a consequence, BCBSM is found not to have violated section 402(1)(e) of Act 350.

B. ADDITIONAL CONCLUSIONS OF LAW

Based upon the statutory law and case law applicable to this matter, the Commissioner makes the following conclusions of law in addition to those adopted from the PFD.

To the extent any of the conclusions of law adopted from the PFD are inconsistent with the conclusions below, the PFD conclusions are superseded. The Commissioner concludes that:

1. BCBSM has failed to establish that IMA should be required to reimburse BCBSM for the claims already paid and which were addressed in the BCBSM audit.
2. There is no evidence that BCBSM's conduct violated section 402(1)(e) of Act 350. (For a similar result concerning the question of section 402 violations, see the 2006 Final Decision in *Daly v BCBSM*, Case No. 04-395-BC, a BCBSM provider audit case in which the Commissioner concluded that BCBSM had not violated section 402.)

V. ORDER

It is ordered that BCBSM is not entitled to the refunds it sought in this matter.



R. Kevin Clinton
Commissioner

STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

In the matter of	Docket No.	2010-132
Internal Medicine Associates of Mt. Clemens, P.C. Jerome Finkel, M.D., Agent, Petitioner	Agency No.	10-763-BC
v	Agency:	Office of Financial and Insurance Regulation
Blue Cross Blue Shield of Michigan, Respondent	Case Type:	Appeal Subscriber/Provider

Issued and entered
this 18th day of February, 2011
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

Appearances: Keith J. Soltis, Attorney at Law, appeared on behalf of the Internal Medicine Associates of Mt. Clemens, P.C., Jerome Finkel, M.D., Agent, Petitioner. Bryant D. Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Respondent.

This matter concerns Respondent's appeal of a Review and Determination under the Michigan Nonprofit Health Care Corporation Reform Act, MCL 550.1101 *et seq.* (Act). On November 5, 2009, the Commissioner's Designee within the Office of Financial and Insurance Regulation (OFIR) issued a Review and Determination, dated November 4, 2009. On January 4, 2010, Respondent filed its Petition for Contested Case Hearing.

On February 3, 2010, the Special Deputy Commissioner within the OFIR issued an Order Referring Complaint for Hearing and Order to Respond. On February 4, 2010, the OFIR filed a Request for Hearing with the State Office of Administrative Hearings and Rules (SOAHR).

This proceeding commenced with the issuance by the SOAHR of a Notice of Hearing dated February 5, 2010, scheduling a contested case hearing for March 10, 2010. On February 26, 2010, at the parties' request, the undersigned issued an Order Converting Hearing Date to Telephone Prehearing Conference.

On March 10, 2010, a telephone prehearing conference was held as scheduled. On March 11, 2010, the undersigned issued an Order Following Telephone Prehearing Conference, setting the hearing date for May 25, 2010.

On April 19, 2010, the undersigned issued an Order Granting Adjournment, at the parties' request, rescheduling the hearing date to July 21, 2010.

On April 23, 2010, Petitioner filed a proof of service for Petitioner's "Initial Discovery Requests". On May 7, 2010, Petitioner filed its witness and exhibit lists.

On May 14, 2010, Petitioner filed Petitioner's Motion to Dismiss and Brief in Support. On May 24, 2010, Respondent filed Respondent's Response to Motion to Dismiss and Brief in Support. On June 8, 2010, the undersigned issued an Opinion and Order Granting in Part Petitioner's Motion to Dismiss, in which Respondent's request for a refund against Jerome Finkel, M.D. individually was dismissed, and the case caption was changed to name Petitioner as "Internal Medicine Associates of Mt. Clemens, P.C., Jerome Finkel, M.D., Agent," as part of the undersigned's proposed decision in this matter.

On June 24, 2010, the undersigned issued an Order Granting Adjournment, at Respondent's request with no objection from Petitioner, rescheduling the hearing date to October 25, 2010. On October 18, 2010, Respondent filed its witness and exhibit lists.

On October 25, 2010, the hearing was held as scheduled. Respondent called Constance (Connie) Blachut to testify as a witness. The following exhibits were offered by Respondent and admitted into evidence:

1. Respondent's Exhibit No. 1 is a copy of a signature page from a "Physician and Professional Provider Participation Agreement" signed by Jerome H. Finkel, M.D., dated July 25, 1990.
2. Respondent's Exhibit No. 2 is a copy of a "Physician and Professional Provider Participation Agreement".
3. Respondent's Exhibit No. 3 is a copy of "Documentation Guidelines for Physicians and Other Professional Providers", effective March 1, 2007.
4. Respondent's Exhibit No. 4 is a copy of Respondent's publication, "The Record" for June 2007.
5. Respondent's Exhibit No. 5 is a copy of Respondent's publication, "The Record" for July 2008.
6. Respondent's Exhibit No. 6 is a copy of a Patient Refund Report.
7. Respondent's Exhibit No. 7 is a copy of a letter to Internal Medicine Associates of Mt. Clemens PC (Petitioner) from Connie Blachut, Manager, Professional Utilization Review, Blue Cross Blue Shield of Michigan, dated September 4, 2008, regarding "Recovery Period: Claims Paid from 08/01/2007 through 07/31/2008".

8. Respondent's Exhibit No. 8 is a copy of a letter to Jerome Finkel (M.D.) from Connie Blachut, Manager, Professional Utilization Review, Blue Cross Blue Shield of Michigan, dated October 20, 2008, regarding "Reconsideration Review for Internal Medicine Associates of Mt. Clemens".
9. Respondent's Exhibit No. 9 is a copy of a letter to Internal Medicine Associates of Mt. Clemens from Connie Blachut, Manager, Professional Utilization Review, Blue Cross Blue Shield of Michigan, dated January 21, 2009, regarding "Managerial Level Conference for Internal Medicine Associates of Mt. Clemens".
10. Respondent's Exhibit No. 10 is a copy of a letter to Susan M. Scarane, Office of Financial and Insurance Services from Jerome H. Finkel, M.D., Internal Medicine Associates, dated September 17, 2009.
11. Respondent's Exhibit No. 11 is a copy of a Review and Determination by Susan M. Scarane, Commissioner's Designee, dated November 4, 2009.
12. Respondent's Exhibit No. 12 is a copy of Respondent's analysis of pay subscriber claims for procedure Code 0144T for Dr. Finkel's patients.
13. Respondent's Exhibit No. 13 is a "web-DENIS" Benefit Detail Record as of November 26, 2007 for Code 0144T.
14. Respondent's Exhibit No. 14 is a copy of Respondent's Medical Affairs Policy Decisions, dated February 24, 2006, and Medical Policy for "Multi-Slice CT Angiography of Coronary Vessels (CCTA)", effective July 1, 2007.

Jerome Finkel, M.D. testified as a witness for Petitioner. The following exhibits were admitted into evidence at Petitioner's request:

1. Petitioner's Exhibit No. 1 is a copy of a letter to Internal Medicine Associates of Mt. Clemens PC from Connie Blachut, Manager, Professional Utilization Review, Blue Cross Blue Shield of Michigan, dated September 4, 2008, regarding "Recovery Period: Claims Paid from 08/01/2007 through July 31, 2008".
2. Petitioner's Exhibit No. 2 is a copy of Respondent's publication, "The Record" for June 2007, with Medical Policy, dated July 1, 2007.
3. Petitioner's Exhibit No. 3 is a copy of Respondent's Request for Contested Case Hearing, with cover letter dated January 4, 2010 sent by fax and regular mail (date stamped "January 05, 2009"); Dr. Finkel's letter to Susan M. Scarane, dated September 17, 2009 with attachments; and Petitioner's Motion to Dismiss, dated May 13, 2010.
4. Petitioner's Exhibit No. 5 is a copy of excerpts from Respondent's newsletter, "The Record," for July 2008 and June 2007.
5. Petitioner's Exhibit No. No. 8 is a copy of Respondent's audit file.

Following the hearing, Respondent filed a request on October 28, 2010 for an opportunity to submit a post-hearing brief. On October 29, 2010, the undersigned issued an Order Scheduling Post-Hearing Briefs, setting the due dates of December 3, 2010 for post-hearing briefs and December 17, 2010 for any reply briefs.

On December 3, 2010, Respondent filed its Post Hearing Brief. On December 6, 2010, Petitioner filed Petitioner's Post-Contested Case Hearing Brief. On

December 17, 2010, Petitioner filed Petitioner's Reply to BCBSM's Post Hearing Brief. The record was then closed.

ISSUE AND APPLICABLE LAW

The issue presented in this matter is whether Respondent has violated Sections 402(1)(a-c), (e) and/or (l) of the Act when conducting a 2008 post-payment review desk audit of Petitioner and demanding repayment in the amount of \$8,738.80.

The applicable sections of the Act provide 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 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.

* * *

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

* * *

(l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement. MCL 550.1402. (Emphasis supplied).

FINDINGS OF FACT

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

1. Petitioner, Internal Medicine Associates of Mt. Clemens P.C., Jerome Finkel, M.D., Agent, is a professional corporation composed of multiple physician shareholders, including Dr. Finkel.

2. The physicians within Petitioner professional corporation likely had individual "participation agreements" with Respondent. A copy of a participation agreement signed by Dr. Finkel in particular is contained in the record. [Resp. Exh. 1 & 2].
3. Respondent's participation agreement allowed it to seek recovery for overpayments which it discovered through audit and stated in pertinent part: "Physician shall promptly report overpayments to BCBSM discovered by Physician, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Physician or BCBSM) from future BCBSM payments. . . . Audit refund recoveries and other overpayment obligations which cannot be fully repaid over the course of one month, will bear interest at the BCBSM prevailing rate, until fully repaid." [Resp. Exh. 1].
4. The procedure in question in this matter is "Code 0144T", which was defined in Respondent's medical policy as "Computed tomography, heart, without contrast material, including image post processing and quantitative evaluation of coronary calcium". Respondent's medical policy indicated that "Computed tomographic angiography (CTA) is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution CT machinery to obtain detailed volumetric images of blood vessels." [Resp. Exh. 14].
5. In November 2004, Petitioner began providing the procedure in Code 0144T in its services to patients. At that time, Petitioner did not bill Respondent for the procedure, but rather required cash or pre-payment

from its patients on the basis that the procedure was a "screening" test and not a covered benefit. [Resp. Exh. 10].

6. As of January 19, 2006, Respondent's "Joint Uniform Medical Policy Committee" had determined the procedure in question to be "investigational" or experimental and not a covered service. It was noted at that time that the procedure required a higher rate of radiation and that its effectiveness had not been proven. [Pet. Exh. 3 – Att. C].
7. In April 2007, Respondent likely began forming a "Coronary CT Angiography Collaborate Quality Initiative" or "CQI" which was intended to be in "partnership with the provider community to insure the effective and judicious use of the emerging imaging technology of CCTA" (cardiac computed tomographic angiography). [Pet. Exh. 3 – Att. C].
8. In June 2007, Respondent issued its newsletter, "The Record," to providers, including Petitioner. In this newsletter, Respondent notified providers that it was forming an "Advanced Cardiac Imaging consortium" and "Coronary CT Angiography Collaborative Quality Initiative" or "CQI" to study the appropriate uses of coronary CT angiography scans, which was a program it expected to launch on July 1, 2007. [Resp. Exh. 4; Pet. Exh. 2].
9. As of July 1, 2007, Respondent's medical policy stated that the procedure in Code 0144T was no longer considered "experimental/investigational" and that it "should be considered a useful diagnostic procedure when indicated." The medical policy stated that within Michigan, the procedure

would be "established" only if delivered in a facility participating in the "CQI" or "if provided by a physician or physician group that participates in the Consortium." Constance (Connie) Blachut, Manager of Respondent's "Professional Utilization Review", credibly testified at hearing that members of the "Consortium" could perform the procedure with training and had to agree to share data. [Resp. Exh. 14, p 3].

10. Per Dr. Finkel's credible testimony, in January 2008, one of Petitioner's patients with a medical savings account needed an insurance "rejection" in order to seek reimbursement from her employer. Petitioner agreed at that time to submit a bill for the procedure to Respondent.
11. Around this same time, Petitioner learned that another of its patients, [REDACTED] had directly submitted a claim to Respondent for the procedure regarding the service date of January 21, 2008, and that he had received reimbursement (minus an "out-of-network sanction") as of February 4, 2008. See the "Explanation of Benefits" in Petitioner's Exhibit No. 3. [Resp. Exh. 10].
12. By fax letter in or around January 2008, Petitioner contacted its representative for Respondent, Yolanda Williams, who indicated that she could not tell if the procedure for Code 0144T was currently covered. Ms. Williams directed Petitioner to Respondent's policy website, which was a secure online portal known as the "webDENIS" benefit guide, for specific information on whether Code 0144T was a payable covered service. [Resp. Exh. 10].

13. In reviewing "webDENIS", Petitioner found that Code 0144T was listed as a covered benefit for "Blue Preferred Plus" (BPP) contracts effective July 1, 2007. [Resp. Exh. 10; Pet. Exh. 3 – Att. D].
14. A printout from "webDENIS", dated February 20, 2008, showed a "Benefit Detail Record as of 11/26/2007", and indicated that Code 0144T was a covered benefit or "payable" for BPP members. It further indicated "Precertification required, Approved PPO providers for office location." The "Provider Type" for office locations included "Anesthesiology, General Surgery, Neurological Surgery, Pediatrics, Radiation, Oncology, Radiology, Radiology Diagnostic". Respondent's "webDENIS" benefit guide did not indicate that the procedure was only payable to "Consortium" or "CQI" provider participants. [Resp. Exh. 13].
15. As of mid-February 2008, Petitioner billed Respondent for the procedure given to patients who were BPP members, using a screening code ("V81.2"), and then received payment from Respondent. (Apparently there was also a "transition" period during which Petitioner sought payment from both Respondent and members, because it was not sure if Respondent would pay the claims.) Petitioner received payment from Respondent for the procedure for 15 patients, per Dr. Finkel's credible testimony.
16. Petitioner did not require pre-payment from some patients, because it understood that the procedure was a covered benefit by Respondent for BPP patients. In submitting billings for these patients to Respondent,

Petitioner's billing personnel did not encounter any "edits" in Respondent's payment system that denied the procedure as not covered or as a non-benefit. Respondent is known to regularly utilize "edits" in its payment system to stop other types of claims that are not properly billed. [Resp. Exh. 10].

17. Dr. Finkel credibly testified that he is an "approved PPO provider" for Respondent. He stated that he does not know if Petitioner's billing personnel sought "pre-certification" for the procedure in question. To his knowledge, the billing staff is very competent and regularly followed Respondent's required billing process. Respondent did not show at hearing that Petitioner had failed to obtain pre-certification or pre-authorization (through Respondent's vendor) as indicated was required on the "web-DENIS" benefit guide for BPP members. No billing or claim documentation was offered into evidence.
18. In July 2008, Respondent issued its newsletter, "The Record" to providers and stated that it was accepting applications until July 31, 2008, from qualified hospitals, cardiology and radiology physician groups "to participate in the coronary computed tomography angiography initiative." The July 2008 newsletter listed the "Consortium" members at that time, including a number of hospitals and four physician groups, and did not include Petitioner on the list. [Resp. Exh. 5; Pet. Exh. 3 – Att. C; Pet. Exh. 5].
19. During the audit period, Petitioner did not apply to become part of the "CQI" or the "Consortium". Petitioner has maintained that the procedure it

performed and billed for as "Code 0144T" did not meet the definition of "coronary computed tomography angiography" or "CCTA" because it did not involve any contrast media, so "The Record" article about the "Consortium" did not apply to it. [Resp. Exh. 10, p 2; Pet. Exh. 3].

20. On September 4, 2008, Respondent requested that Petitioner reimburse it in the amount of \$8,738.80, for payments it had made to Petitioner for services rendered to 44 patients by physicians within Petitioner professional corporation, for an audit period of August 1, 2007 to July 31, 2008. [Resp. Exh. 7; Pet. Exh. 1].
21. Per Ms. Blachut's credible testimony, around this same time a couple of providers other than Petitioner voluntarily refunded Respondent for payments made for the procedure.
22. Petitioner stopped billing for the procedure after it received Respondent's letter of September 4, 2008, per Dr. Finkel's credible testimony.
23. Petitioner requested a "Reconsideration" of the refund request from Respondent. On October 28, 2008, Respondent notified Petitioner by letter that after its review the refund amount remained at \$8,738.80. [Resp. Exh. 8].
24. On January 14, 2009, a "Managerial Level Conference" was held, after which Respondent continued to maintain its refund request at \$8,738.80 for "[p]rojected overpayment for non medical necessity codes". Respondent stated the following to Petitioner in writing after the Managerial Level Conference:

Procedure Code 0144T is within the range of codes denoted as multi-slice CT angiography of coronary vessels. Formerly, these codes were considered investigational by BCBSM. BCBSM has been investigating CCTA procedures to evaluate the appropriateness of using these procedures to replace conventional cardiac catheterization. BCBSM developed a Cardiac Consortium to evaluate the safety and efficacy of these codes. Only providers in the consortium are paid for codes in the range of 0144T through 0151T. During the MLC, you acknowledged that you have access to web-DENIS. The BCBSM policy pertaining to these codes is very specific in identifying the code range as well as the screen procedure exclusions. You indicated you used the screening diagnosis V81.2 when you bill 0144T. BCBSM medical policy does not pay for screening procedures. You also acknowledged you are aware that according to your BCBSM participation agreement you are responsible for returning incorrect payments to BCBSM. Therefore, our decision to recover the refund has been maintained. [Resp. Exh. 9 (emphasis supplied)].

25. In or around the relevant audit time period, Respondent likely approved payment for Code 0144T procedures given to "Blue Preferred Provider" (BPP) members by non-"CQI" or non-"Consortium" providers.
26. The specific type of procedure in question may not have been considered "angiography" from a medical standpoint at that time. Alternatively, Respondent may well have chosen to carve out an exception for BPP members, from its otherwise-stated medical policy. It has not been shown on this record that the payments made by Respondent to Petitioner regarding BPP members during the relevant audit time period were likely done in error or mistake.
27. One of Petitioner's patients was likely recently informed by Respondent personnel that the procedure was a payable service, per Dr. Finkel's credible testimony.

28. Respondent did not have an "edit" in its claims processing system to automatically reject claims with a "screening diagnosis" for all providers. Per Ms. Blachut's credible testimony, it is likely that the lack of an "edit" was related to the procedure having been done initially in hospitals within the "Consortium", where the billing process was different than for individual providers.
29. Petitioner likely relied to its detriment upon Respondent approving payments for Code 0144T, to the extent that it did not require pre-payment for the procedure in question from BPP members, that it likely incurred expense in giving the procedure to patients, and that it may prove difficult to obtain reimbursement from patients who previously understood the procedure was a covered benefit. The record evidence does not show, however, that Petitioner is necessarily precluded from seeking reimbursement from patients should it be required to refund the amount in question to Respondent.
30. The Review and Determination of the Commissioner's Designee, dated November 4, 2009, and mailed to Respondent on November 5, 2009 (per the Proof of Service) concluded that Respondent had violated Section 402(1)(e) of the Act by "failing to affirm or deny coverage of a claim within a reasonable time after a claim has been received when it pursued a refund request of Petitioner for \$8,738.80 based upon its contention Petitioner was not part of BCBSM's consortium for CCTA services. BCBSM failed to consistently apply its own medical policy properly when it processed CCTA related claims." [Resp. Exh. 11, p 8].

31. The Review and Determination stated that Respondent had paid consortium providers, non-consortium providers and members for non-covered services, but was now attempting to recover payments made only to non-consortium providers. It was concluded that Respondent was "not entitled to pursue its refund request of Petitioner". [Resp. Exh. 11, p 9].
32. On January 4, 2010, Respondent likely filed a timely appeal, entitled "Request for Contested Case Hearing," within 60 days of the date of mailing of the Commissioner Designee's Review and determination. The "Request for Contested Case Hearing" document contained in the record bears a date-stamp from the Office of Financial and Insurance Regulation of "Jan 05 2009" [sic]. The cover letter from Respondent's counsel with the "Request for Contested Case Hearing," however, has a date of "January 4, 2010" and indicates that it was sent by both fax and regular mail. [Pet. Exh. 3]. The Complaint document contained in the record, prepared by the Office of Financial and Insurance Regulation, also refers to Respondent's request for hearing as being dated "January 4, 2010".

CONCLUSIONS OF LAW

Respondent, as the party in effect appealing the Commissioner Designee's Review and Determination, has the burden of proof to show by a preponderance of the evidence that grounds exist to reverse the Review and Determination in whole or in part. See generally, MCL 550.1402 and 1986 AACS, R 550.107(3). Here, it is concluded that Respondent has failed to meet its burden of proof.

Based on the above findings of fact, Respondent has not shown that the refund request amount of \$8,738.80 constitutes mistaken payments to Petitioner. Rather, the record evidence shows that for the audit period of August 1, 2007 to July 31, 2008, it is more likely than not that Respondent knowingly approved payments to Petitioner for the procedure in question even though that may have contradicted its stated medical policy at that time. In or around the time of the audit period, Respondent's online benefit guide, "webDENIS," likely indicated to providers that the procedure was covered for certain of its subscribers, being "Blue Preferred Plus" members with pre-certification. Respondent did not show in its proofs at hearing that Petitioner had failed to obtain the pre-certification or authorization for the billed claims or that Petitioner billed for patients who were other than "Blue Preferred Plus" members. As the refund request amount has not been shown to be the result of mistake or error, the Michigan case law cited by Respondent on recovering mistaken payments is not applicable to this matter. See, *Walker v Conant*, 65 Mich 194; 31 NW 786 (1887); 69 Mich 321; 37 NW 292 (1888).

It is therefore concluded that Respondent has failed to "affirm or deny coverage of a claim within a reasonable time after a claim has been received", contrary to Section 402(1)(e) of the Act, *supra*. No other violation of Section 402 of the Act has been established. Accordingly, Respondent has not shown that the decision of the Commissioner Designee's Review and Determination in this matter should be reversed.

PROPOSED DECISION

The undersigned Administrative Law Judge proposes the following to the Commissioner:

1. That the above findings of fact and conclusions of law be adopted in the Commissioner's final decision and order in this matter;
2. That the Commissioner affirm the undersigned's proposed ruling of June 8, 2010, in the Opinion and Order Granting in Part Petitioner's Motion to Dismiss;
3. That the Commissioner find that Respondent is not entitled to pursue its refund request of \$8,738.80 from Petitioner, and affirm the decision in the Commissioner Designee's Review and Determination of November 4, 2009; and
4. That the Commissioner take any other action as deemed appropriate under the provisions of the Act.

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, 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