

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

Comprehensive Hematology  
Oncology Physicians  
Petitioner

MAHS Case No. 12-001323-OFIR

V

Case No. 12-890-BC

Blue Cross Blue Shield of Michigan  
Respondent

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Issued and entered  
this 21<sup>st</sup> 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, Comprehensive Hematology Oncology Physicians (Comprehensive). BCBSM audited the Comprehensive's office infusion services records for the calendar year 2009. Based on its audit findings, BCBSM concluded that Comprehensive had failed to properly document claims it had submitted to BCBSM. Consequently, BCBSM sought recovery of \$90,210.32 from the physician group.

A Review and Determination proceeding was held by the Commissioner's designee.<sup>1</sup> The review and determination considered in detail the audit findings for seven of the patients whose records were audited by BCBSM.

Based on this analysis, the Commissioner's designee concluded that BCBSM should only be permitted to recover 59.7 percent of the amount it sought. The Commissioner's designee also felt that BCBSM had failed to submit records needed to properly document its refund request. The Commissioner's designee then reduced the refund amount to \$53,336.03 then applied the 59.7 percent resulting in a refund of \$31,841.61 ( $\$53,336.03 \times .597$ ).

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

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1. See MCL 550.1404.

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 scheduled for September 4, 2012. On August 31, 2012, the attorney who represented Petitioner Comprehensive at the Review and Determination filed a notice that Comprehensive was no longer operating a medical practice. No one representing the Petitioner appeared at the September 4 hearing. The hearing was rescheduled for November 1, 2012, with new hearing notices sent to each of the physicians affiliated with Comprehensive. Once again, no one appeared on behalf of Comprehensive. The hearing proceeded in the absence of the Petitioner.

The administrative law judge issued a Proposal for Decision (PFD) on December 26, 2012. In the PFD, the administrative law judge rejected the analysis of the Commissioner's designee and 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 \$90,210.32 from Comprehensive Hematology Oncology Physicians.

Neither party filed exceptions to the PFD. Michigan courts have long recognized that the failure to file exceptions constitutes a waiver of any objections not raised. *Attorney General v Public Service Comm* 136 Mich App 52 (1984).

## II. FINDINGS OF FACT

The findings of fact in the PFD are supported by the hearing record. The Commissioner adopts and incorporates those findings of fact as part of this order. 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.

**IV. ORDER**

It is ordered that:

1. BCBSM did not violate section 402(1)(f) of Act 350.
2. BCBSM may recover \$90,210.32 from Comprehensive Hematology Oncology Physicians.



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R. Kevin Clinton  
Commissioner

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STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

OFIR/UGC

IN THE MATTER OF:

Docket No. 12-001323-OFIR

Comprehensive Hematology  
Oncology Physicians,  
Petitioner

Agency No. 12-890-BC

Agency: Office of Financial & Insurance  
Regulation

v

Blue Cross Blue Shield of Michigan,  
Respondent

Case Type: OFIR/OFIS Insurance

Filing Type: Appeal  
Subscriber/Provider

Issued and entered  
this 26<sup>th</sup> day of December 2012  
by Lauren G. Van Steel  
Administrative Law Judge

COPY

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

Appearances: Bryant D. Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Respondent. No appearance by an attorney or representative was entered on behalf of Comprehensive Hematology Oncology Physicians, Petitioner.

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 July 30, 2012, which scheduled a contested case hearing for September 4, 2012. The notice of hearing was issued pursuant to a request for hearing filed by the Office of Financial and Insurance Regulation on July 27, 2012, along with an Order Referring Complaint for Hearing and Order to Respond and Complaint issued by Randall S. Gregg, Special Deputy Commissioner, on July 27, 2012.

The Complaint references allegations set forth in Respondent's Petition for Contested Case Hearing, dated July 26, 2012, by which Respondent seeks reversal of the Review and Determination issued by the Commissioner's Designee on May 30, 2012, which concluded that Respondent was in violation of Section 402(1)(f) of the Nonprofit Act and reduced the amount of its refund request.

On August 27, 2012, Respondent filed a Motion to Enter Decision against Petitioner by Default, based on Petitioner's failure to file an Answer as required by the Order Referring Complaint and Order to Respond.

On August 31, 2012, Keith J. Soltis, Attorney at Law, filed notice that Petitioner is "no longer operating a medical practice and has not authorized any response or appearance by counsel in this matter. Blue Cross Blue Shield of Michigan has been made aware of these facts." Attorney Soltis did not file an appearance on behalf of Petitioner in the present matter before the Michigan Administrative Hearing System, but had represented Petitioner at the prior review and determination proceeding before the Commissioner's Designee.

On September 4, 2012, the hearing commenced as scheduled. Attorney Greene appeared on behalf of Respondent. No one appeared on behalf of Petitioner. The undersigned determined on the record to continue the hearing, in order that all known principals of Petitioner's group practice be properly served with notice of hearing, in that only Attorney Soltis had been sent notice of the September 4, 2012 hearing date per the request for hearing filed by the Office of Financial and Insurance Regulation.

On September 11, 2012, Respondent filed a statement regarding the names and addresses of "physicians that made up the above referenced practice" as follows: Enrique Signori, M.D., Renu Pandit, M.D. and Oscar Signori, M.D., Comprehensive Hematology Oncology Physicians, 4900 Mercury Drive, Suite 100, Dearborn, Michigan 48126. On September 20, 2012, the undersigned issued an Order for Continuance that scheduled the continued hearing for November 1, 2012. The Order for Continuance was sent to the above-listed persons at the last known address for Petitioner. The mailing was not returned by the post office.

On November 1, 2012, the continued hearing was held as scheduled. Attorney Greene appeared on behalf of Respondent. No one appeared at hearing on behalf of Petitioner. The hearing proceeded in the absence of Petitioner following proper notice, pursuant to Section 72(1) of the Administrative Procedures Act, 1969 PA 306, as amended, MCL 24.272(1).

The undersigned administrative law judge denied Respondent's Motion to Enter Decision against Petitioner by Default for reasons stated on the record, specifically Respondent's burden of proof in this contested case proceeding and the discretionary default language in the Order to Respond. The hearing then proceeded with Respondent's proofs.

Respondent presented David Keener, R.Ph. as a witness. In addition, Respondent offered the following exhibits that were admitted into the record as evidence:

1. Respondent's Exhibit No. 1 is a Statement of Facts prepared by Respondent, dated November 1, 2012.
2. Respondent's Exhibit No. 2 is a copy of Respondent's Petition for Contested Case Hearing, dated July 26, 2012; Review and Determination, dated May 30, 2012; audit letter to Petitioner from Respondent, dated May 28, 2010; letter following managerial level conference to Petitioner from Respondent, dated April 13, 2011; and Respondent's position summary to the Commissioner's Designee, dated January 30, 2012.
3. Respondent's Exhibit No. 3 is a copy of the Notice of Hearing for September 4, 2012, issued by the Michigan Administrative Hearing System on July 30, 2012.
4. Respondent's Exhibit No. 4 is a copy of Respondent's Motion to Enter Decision against Petitioner by Default, dated August 27, 2012.
5. Respondent's Exhibit No. 5 is a copy of Respondent's Patient Refund Credit Report, dated October 4, 2011, regarding an audit of Comprehensive Hematology Oncology Physicians for January 1, 2009 to December 31, 2009.
6. Respondent's Exhibit No. 6 is a copy of Respondent's document, Provider Manual Chapter: Documentation Guidelines for Physicians and Other Professional Providers, dated January 28, 2009, with attachments.
7. Respondent's Exhibit No. 7 is a copy of Respondent's Case Detail Profiling Report, dated October 3, 2011, with medical records for patient S.F. (initials used for confidentiality purposes).
8. Respondent's Exhibit No. 8 is a copy of Respondent's Case Detail Profiling Report, dated October 3, 2011, with medical records for patient D.P.
9. Respondent's Exhibit No. 9 is a copy of Respondent's Case Detail Profiling Report, dated October 3, 2011, with medical records for patient D.L.
10. Respondent's Exhibit No. 10 is a copy of a Projection Example for Audit ID #201000875.

No evidence was presented on Petitioner's behalf. The record was closed at the conclusion of the hearing.

**ISSUES AND APPLICABLE LAW**

The issues presented are:

1) Whether the established facts evidence a violation by Respondent of Section 402(1)(f) of the Nonprofit Act, *supra*, as concluded in the Review and Determination; and

2) Whether Respondent's request for refund should be reduced from \$90,210.32 to \$31,841.61, as set forth in the Review and Determination.

Section 402(1)(f) of the Nonprofit Act provides as follows:

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

(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. MCL 550.1402(1)(f).

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 AACS, 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 AACCS, 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 AACCS, R 550.108.

### FINDINGS OF FACT

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

1. At times relevant, Comprehensive Hematology Oncology Physicians, Petitioner, was a participating provider of health care services with Blue Cross Blue Shield of Michigan, Respondent. It was a group practice of physicians specializing in hematology and oncology medicine located at 4900 Mercury Drive, Suite 100, in Dearborn, Michigan. [Resp. Exh. 2].
2. Payment by Respondent for services rendered to member patients was governed by a "Physician and Professional Provider Participation Agreement," which provided that claims for reimbursement filed by Petitioner were subject to audit under certain conditions. [Resp. Exh. 2].
3. The Participation Agreement allowed Respondent to extrapolate its refund requests from samples of patient files that were reviewed in an audit. Addendum H to the Participation Agreement stated in pertinent part:

"BCBSM [Respondent] shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary as determined by BCBSM under Addendum 'A'. . . . BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than medical necessity, including, but

not limited to, procedure code billing errors.” [Resp. Exh. 2, Participation Agreement, p 19 (Emphasis supplied)].

4. In March 2010, Respondent conducted a timely “compliance” audit of claims paid to Petitioner during the period of January 1, 2009 to December 31, 2009. [Resp. Exh. 2 & 5].
5. Respondent’s auditors reviewed a random sample of 81 patient records from a population of 137, per the credible testimony of Respondent’s witness, David Keener, R.Ph., who is the Manager of the Utilization Review department within Blue Cross Blue Shield of Michigan. [Resp. Exh. 10].
6. Mr. Keener credibly testified that in a “compliance” audit, Respondent’s auditors review patient records for compliance with the Participation Agreement. There were no medical necessity determinations made in this particular audit.
7. Mr. Keener credibly testified that physician providers are chosen by Respondent for audit based on a review of payment claims data. Petitioner was given timely notice of the audit.
8. Respondent’s auditors used a random sample of files from the entire population of claims for a one-year period according to well-established methodology, per Mr. Keener’s credible testimony. Petitioner was provided with a list of the 81 patient files in the sample prior to the auditors appearing at Petitioner’s location for the audit.
9. Mr. Keener credibly testified that the auditors for Respondent are experienced and trained. At the end of each audit day, the auditors prepare a “missing documentation” list that is given to the provider. During the audit, the auditors copy the records that are relevant to any deficiency findings. The auditors do not copy every record that is reviewed. At the conclusion of the audit, the auditors meet with the provider’s representative and explain their preliminary findings. They then review all of the records obtained and prepare an audit letter with the findings summarized in the attachments. Mr. Keener then signs a letter to the provider giving the audit findings.
10. Per Mr. Keener’s credible testimony, there is an opportunity given to the provider for reconsideration of the audit findings, in which the provider can submit additional documentation if it chooses to do so.
11. In the statistical projection process, Respondent takes the number of errors identified with the dollar amount associated, divided by the number of patients in the sample, to obtain a refund amount per patient.

Respondent then applies the error rate to the total patient population for the extrapolated refund request amount, per Mr. Keener's credible testimony. [Resp. Exh. 10].

12. At the conclusion of the audit of Petitioner's files, Respondent determined that certain of Petitioner's payment claims did not meet the required documentation guidelines in several respects. See page 2 of Respondent's position summary to the Commissioner's Designee, dated January 30, 2012, and Provider Guidelines. [Resp. Exh. 2].
13. In part, Respondent's auditors used denial codes "NB" (not a benefit), "IO" (incomplete order) and "NO" (no order) in respect to certain audited paid claims. [Resp. Exh. 2 & 5].
14. Respondent's initial request to Petitioner for refund following the audit totaled \$97,982.23. [Resp. Exh. 2].
15. Following Petitioner's request for reconsideration, Respondent reduced the refund request amount to \$95,531.33 on May 28, 2010. [Resp. Exh. 2].
16. On March 25, 2011, a managerial level conference was held between the parties, in which Mr. Keener and Respondent's Ph.D. statistician participated. Petitioner was provided another opportunity to submit additional documentation relevant to the audit findings. Following the managerial level conference, Respondent reduced the refund request amount to \$90,210.32 on April 13, 2011. [Resp. Exh. 2].
17. On July 28, 2011, Petitioner appealed the managerial level conference decision and requested a review and determination by the Commissioner of Financial and Insurance Regulation. [Resp. Exh. 1 & 2].
18. On October 5, 2011, Susan M. Scarane, Commissioner's Designee, held a meeting with the parties, in which seven patient files were specifically reviewed. Mr. Keener participated in the review and determination meeting. Petitioner was afforded another opportunity to submit relevant patient records, per Mr. Keener's credible testimony. [Resp. Exh. 2].
19. On May 30, 2012, the Commissioner's Designee issued a Review and Determination decision, which concluded that Respondent was in violation of Section 402(1)(f) of the Nonprofit Act, and reduced the requested refund amount to \$31,841.61. [Resp. Exh. 2].
20. In the Review and Determination decision, the Commissioner's Designee found that the entire projection associated with the refund request should not be considered because "it is felt that complete and accurate patient

records were not copied by BCBSM.” [Resp. Exh. 2, Review and Determination, p 15].

21. In particular, the Commissioner’s Designee found that Respondent’s auditors had only copied the portion of the patient medical records that they found questionable, “meaning that no one throughout the audit appeal process had the entire patient record to review. As such, it was nearly impossible to determine if orders written by physicians might have been on the documents BCBSM decided not to copy (e.g. laboratory reports).” [Resp. Exh. 2, Review and Determination, p 15 (Emphasis supplied)].
22. The Commissioner’s Designee also found that Respondent had changed its denial codes at some point during its internal appeal process. On that basis, the Commissioner’s Designee determined to give deference to Petitioner for the services in dispute. [Resp. Exh. 2, Review and Determination, pp 15-16].
23. The Commissioner’s Designee concluded that Respondent had violated 402(1)(f) of the Nonprofit Act by failing to make a good faith attempt at a prompt, fair and equitable settlement on denied claims for seven patients, totaling \$15,947.62, which represented 40.3% of the total refund requested for seven patients reviewed. The Commissioner’s Designee then applied this percentage to the “remaining refund request of \$53,336.03” and concluded that the refund request should be reduced to \$31,841.61. [Resp. Exh. 2, Review and Determination, p 18].
24. The Review and Determination decision took out the difference between \$90,210.32 and the audit sample overpayment of \$53,336.03, as identified by Respondent in its managerial level conference findings. [Resp. Exh. 2, Review and Determination, p 15].
25. Mr. Keener credibly testified that the Respondent’s auditors did in fact review the entire patient records in the sample at the time of the audit and Petitioner had several opportunities to submit any additional records that were not copied for subsequent review in the appeals process.
26. Respondent’s Exhibit Nos. 7, 8 and 9 credibly show the extent and depth of patient medical records that were reviewed by the auditors.
27. Respondent’s admitted exhibits, specifically the position summary of January 30, 2012, and the audit summary, credibly show a reasonable basis for the change in denial codes in the refund request, contrary to the Review and Determination findings. [Resp. Exh. 2, position summary, pp 4-9; Review and Determination, pp 16-18].

28. Respondent's admitted exhibits and Mr. Keener's credible and unrefuted testimony reasonably supports Respondent's total requested refund amount of \$90,210.32.

### CONCLUSIONS OF LAW

As the complaining or appealing party, Respondent 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 Respondent has met its burden of proof, to show that its refund request of \$90,210.32 should not be reduced. The stated reasons for reduction, as set forth in the Review and Determination, were not supported by a preponderance of evidence presented at hearing.

Further, the Commissioner's Designee concluded in the Review and Determination that Respondent was in violation of Section 402(1)(f) of the Nonprofit Act by failing to make a good faith attempt at a prompt, fair and equitable settlement. No other subsection of Section 402(1) was found to have been violated. Based on the above findings of fact, it is concluded that a preponderance of evidence does not show that Respondent 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." Rather, the record evidence shows that it is more likely than not that Respondent did attempt in good faith to make a prompt, fair and equitable settlement of the paid claims at issue through the reconsideration, managerial level conference and review and determination levels.

It has been decided in similar provider/subscriber appeals before the Commissioner that it is not appropriate to find a violation of Section 402(1)(f) of the Nonprofit Act when claims were actually paid and Respondent acted to recover the amounts that its audit concluded were overpayments. See the Commissioner's final decisions in *Whole Health Medical Center, P.C. v Blue Cross Blue Shield of Michigan*, Case No. 11-802-BC, Docket No. 11-000794-OFIR (August 3, 2012); and *Internal Medicine Associates of Mt. Clemens v Blue Cross Blue Shield of Michigan*, Docket No. 2010-132, Case No. 10-763-BC, (June 29, 2011).

Here, the record evidence shows that payments at issue had already been made to Petitioner and the audit findings reasonably sought a refund. A preponderance of the evidence presented at hearing supported the requested refund amount. In that context, it has not been shown that Respondent failed to attempt in good faith to make a prompt, fair and equitable settlement. Therefore, no violation of Section 402(1)(f) of the Nonprofit Act has been established in this matter.

**PROPOSED DECISION**

The undersigned Administrative Law Judge proposes that the Commissioner issue a Final Decision that adopts the above findings of fact and conclusions of law, and reverses the Review and Determination's conclusion that Respondent is in violation of Section 402(1)(f) of the Nonprofit Act.

It is further proposed that the Final Decision reverse the Review and Determination's conclusion that Respondent's refund request should be reduced, and conclude that Respondent is entitled to seek refund from Petitioner in the total amount of \$90,210.32.

**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.

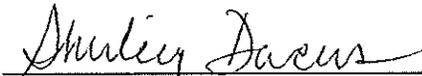


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**Lauren G. Van Steel**  
**Administrative Law Judge**

**PROOF OF SERVICE**

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed below this 26<sup>th</sup> day of December, 2012.

  
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Shirley Dacus  
Michigan Administrative Hearing System

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