

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

[REDACTED]

Petitioner,

v

File No. 153388-001-SF

State of Michigan, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 17th day of May 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 25, 2016, [REDACTED] (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495). On May 2, 2016, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a group plan sponsored by the State of Michigan (the State Health Plan or the plan), a self-funded governmental health plan subject to Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director immediately notified BCBSM of the external review request and asked for the information it used to make the plan's final adverse determination. BCBSM responded on April 28 and May 10, 2016.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

This case presents an issue of contractual interpretation. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner’s health care benefits are described in a booklet called *Your Benefit Guide - State Health Plan PPO* (the benefit guide).

The Petitioner was experiencing pain in her jaw and neck. Her chiropractor, believing the pain was related to temporomandibular joint (TMJ) disorder, referred her to [REDACTED], [REDACTED], in October 2015. In November 2015, the Petitioner was evaluated by [REDACTED] and subsequently received these services:

Procedure Code	Description	Provider’s Charge
99204	Office or other outpatient visit for the evaluation and management of a new patient	\$ 250.00
20999	Unlisted procedure, musculoskeletal system, general	39.00
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser	63.00
	Total	\$ 352.00

When claims for these services were submitted to the plan, BCBSM denied coverage. The Petitioner appealed the denial through the plan’s internal grievance process. After a managerial-level conference BCBSM issued a final adverse determination dated April 15, 2016, upholding the denial. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Was the plan correct when it denied coverage for the services from [REDACTED]?

IV. ANALYSIS

In the final adverse determination, BCBSM’s representative explained the plan’s denial to the Petitioner:

... After review, I confirmed that BCBSM’s original payment determination ... was correct. The services you received are not covered if they are performed by a

provider of [REDACTED] type and specialty. As a result, I must maintain denial of payment for the charges of \$352.00.

You are covered under the State Health Plan, and your benefits are set forth in *Your Benefit Guide State Health Plan PPO*. On Page 10, *Your Benefit Guide* explains your coverage for dental surgery:

Dental surgery performed on an inpatient basis is covered if the patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. Surgery must be performed by an MD or DO. Dental procedures performed by a DDS must be billed to the dental program.

Because your provider performed this surgery in an office setting, and is credentialed as a DDS, the surgical service you received - procedure code 20999 (musculoskeletal surgery, unlisted) is not covered under your health care coverage.

This is supported by BCBSM's *Benefit Package Report* for your group's coverage that the other services that were provided – procedure codes 99204 (office / outpatient visit, new patient, 45minutes) and S8948 (low level laser treatment, 15 minutes) - are not covered when they are performed by a provider of [REDACTED] type and specialty (oral surgery / dentist). As a result, BCBSM is unable to offer payment for these services.

I do understand that [REDACTED] was recommended to you, and that she was one of the few providers reflecting the services you received. However, BCBSM is required to administer benefits in accordance with the contractual provisions of your group coverage, and I am unable to make an exception on your behalf.

To ensure that every consideration has been extended to your appeal, I requested your medical records reflecting the services you received. However, to date those records have not been received. If they are received in the future, a medical review may be conducted.

In her external review request, the Petitioner stressed that [REDACTED] did not perform surgery:

There wasn't any surgery performed. Please review my record of the visit. All we did was an exam, laser treatment and she gave me a bite guard.

The Petitioner contends that procedure code 20999 was for a "bite guard," not surgery. This is confirmed by the notes from [REDACTED] office for November 3, 2015, which indicates that a type of temporary dental splint used to provide relief from TMJ pain (called an Aqualizer Ultra) was prescribed.

The services the Petitioner received are seemingly dental-related: an office visit, a dental

splint, and laser treatment for jaw pain. But the State Health Plan does not generally cover dental care – it provides medical benefits. Coverage for dental-related services in the benefit guide is limited to two circumstances, neither of which apply in the Petitioner’s case: 1) certain inpatient surgery performed by an MD or a DO because the patient has a medical condition that makes it unsafe to be performed in an office setting, and 2) dental care arising out of an accident or in an emergency.

The Petitioner did not have inpatient surgery nor was her dental care needed because of an emergency or accidental injury. The Director therefore concludes that the services performed by [REDACTED] were not benefits under the terms and conditions of the plan.

V. ORDER

The Director upholds the plan’s final adverse determination of April 15, 2016.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director