

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

In the matter of:

██████████,
Petitioner,

v

File No. 153046-001-SF

University of Michigan, Plan Sponsor,

and

Blue Care Network Service Company, Plan Administrator,
Respondents.

Issued and entered
this 26th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 4, 2016 ██████████ (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) MCL 550.1951 *et seq.*

The Petitioner receives health care benefits through a group health plan sponsored by the University of Michigan (the plan), a self-funded governmental health plan as defined in Act 495. The plan is administered by the BCN Service Company (BCNSC), a licensed third party administrator. The Director immediately notified BCNSC of the external review request and asked for the information it used to make its final adverse determination. BCNSC responded on April 8 and April 11, 2016.

On April 11, 2016, after a preliminary review of the information submitted, the Director accepted the Petitioner's request.

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 involves 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 retiree health care benefits are described in the plan's *U-M Premier Care Benefit Document* (the benefit document). The benefit document is amended by *U-M Premier Care 65 Complementary Medicare Amendment* which applies to the Petitioner because he is enrolled in Medicare Parts A and B as his primary coverage; the plan's coverage is supplemental. The Petitioner also receives dental benefits through Delta Dental Plan of Michigan.

On January 10, 2015, the Petitioner was referred to an oral surgeon for evaluation of a possible jaw infection. On January 29, 2015, he had surgery to place a bone graft in his jaw. The amount charged for this care was \$1,564.00. According to the Petitioner, his "secondary medical insurance" paid \$652.30, leaving a balance of \$911.50 which the Petitioner wants the plan to cover.

Acting for the plan, BCNSC denied coverage, saying the surgery was dental in nature and therefore not a covered benefit.

The Petitioner appealed the denial through the plan's internal grievance process. BCNSC held a managerial-level conference and issued a final adverse determination for the plan dated March 11, 2016, upholding the decision. 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 Petitioner's bone graft surgery?

IV. ANALYSIS

Petitioner's Argument

On the external review request form the Petitioner wrote:

[The plan] states they cannot approve my claim for \$1564 because the service was dental in nature. My secondary insurance paid \$652.50 of this on 3 March 2016. All procedure codes CPT are medical codes and carried out to resolve a jaw bone infection. My family doctor referred me to [the oral surgeon]. I believe that [the plan] wrongfully concluded that my serious medical problem was a simple case of a tooth implant.

In a March 30, 2016, letter included with his request, the Petitioner said:

It is my opinion that [the plan] wrongfully concluded . . . that my claim was for simple dental work followed by a dental implant. This oral surgery was not "dental" in nature as [the plan] states. I also believe that the infection involved a cyst in the jaw as my family doctor diagnosed jaw disease . . . that seems to be covered by my insurance. I was treated for a medically necessary condition. . . .

1. My problem started when tooth number 13 was extracted on 4/30/14. Treatment for a cyst or infection began and continued until 1/29/15.
2. On 10 June 2014 [my oral surgeon] provided a treatment plan that was needed to save my upper jawbone. There was no decision to have a tooth implant at that time. I still do not have a replacement for tooth #13. . . .

The Petitioner believes that his oral surgery was medical in nature and should be covered by the plan.

Plan's Argument

In the final adverse determination issued to the Petitioner, BCNSC said:

. . . The [grievance] Panel . . . reviewed your request for authorization and reimbursement of your payment of the bone grafting procedure.

The Panel reviewed the information you submitted, including the additional faxed information received on 03/10/2016 and the information provided during the Panel meeting, along with the medical documentation submitted by the Dentist . . . and the out of network Oral Surgeon. . . . Additionally, the Panel reviewed your UM Premier Care Benefit Document and the BCN Medical Policy Mandibular and Maxillary Implants Medical Policy. The Panel maintained the denial of your request stating that per the UM Premier Care Benefit Document Section 9.12, Dental Service: There is no coverage for dental services, dental prosthesis, restoration or replacement of teeth, X-rays, oral surgery or anesthesia for dental procedures even if related to a medical condition or treatment.

Director's Review

The Petitioner had oral surgery to place a bone graft in his upper left jaw. The benefit for oral surgery is defined in subsection 8.22, "Oral Surgery" (p. 47):

NOTE: Dental services are not covered. See Section 9 for additional exclusions.¹

Oral surgery and X-rays are covered only when BCN preauthorizes them for:

¹ The exclusion of dental services is in subsection 9.12 of the benefit document (p. 57): "There is no Coverage for dental services, dental prosthesis, restoration or replacement of teeth, X-rays, oral surgery or anesthesia for dental procedures even if related to a medical condition or treatment except as specifically stated in Section 8."

- Treatment for fractures or suspected fractures of the jaw and facial bones and dislocation of the jaw;
- Dental anesthesia in an outpatient setting when Medically Necessary and approved by BCN;
- Medically Necessary surgery for removing tumors and cysts within the mouth.

* * *

- Oral surgery and dental services necessary for the immediate repair of trauma in the jaw, natural teeth, cheeks, lips, tongue and roof and floor of the mouth. NOTE “immediate” means treatment within 72 hours of the injury. Any follow up treatment performed after the first 72 hours post-injury is not covered.

Bone graft surgery of the jaw is not included in the list of covered oral surgery services in subsection 8.22. It is considered to be a dental service and is therefore not a benefit under the plan.

The Director finds that the plan’s denial of coverage for the Petitioner’s January 29, 2015, oral surgery is consistent with the provisions of the benefit document.

V. ORDER

The Director upholds the plan’s final adverse determination of March 11, 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 Michigan 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