

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

Contemporary Imaging Associates,
Petitioner

v

Blue Cross Blue Shield of Michigan,
Respondent

Docket No. 2010-132

Case No. 10-763-BC

Issued and entered
this 16th day of May 2012
by R. Kevin Clinton
Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan of one of its participating providers, Contemporary Imaging Associates. Based on its audit findings, BCBSM concluded it had overpaid the provider \$178,113.30 during the audit period, October 7, 2004 through December 31, 2005.

The provider disputed BCBSM's findings. A Review and Determination proceeding was held by the Commissioner's designee¹ who concluded that BCBSM had violated section 402(1)(l) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(l). The Commissioner's designee also concluded that BCBSM was not entitled to recover the funds in question because BCBSM's recovery efforts were in violation of the audit and recovery provisions of the provider agreement between the parties which imposes a two year limitation on such recovery efforts.

The decision was appealed to the Commissioner by BCBSM. A contested case hearing was scheduled. Prior to the hearing, Contemporary Imaging Associates filed a motion for summary decision. Both parties filed briefs on the motion and oral argument was held on February 1, 2012. During oral argument, the parties stipulated to the entry of five exhibits.

The administrative law judge issued a Proposal for Decision (PFD) on February 9, 2012, granting the motion. In the PFD, the administrative law judge recommended that the

1. See MCL 550.1404.

Commissioner find that (1) BCBSM violated section 402(1)(l) of Act 350, and (2) BCBSM not be entitled to pursue recovery of the alleged overpayment. Neither party has filed exceptions to the PFD.

II. FINDINGS OF FACT

The findings of fact in the PFD are based on information contained in the five joint exhibits. Those exhibits are:

Exhibit 1	October 6, 2006 letter from BCBSM to Contemporary Imaging
Exhibit 2	April 18, 2008 letter from BCBSM to Contemporary Imaging
Exhibit 3	June 9, 2008 letter from BCBSM to Contemporary Imaging
Exhibit 4	March 13, 2009 letter from BCBSM to Contemporary Imaging
Exhibit 5	Participation Agreement, Addendum H

Because the findings of fact in the PFD are supported by the information in the joint exhibits, the Commissioner adopts and incorporates those findings of fact in this order. The PFD is attached.

III. CONCLUSIONS OF LAW

The Commissioner finds that the conclusions of law stated in the PFD regarding BCBSM's ability to recover alleged overpayments in 2004 and 2005 are properly grounded in the facts of this case and are soundly reasoned. Those findings are adopted.

The Commissioner does not adopt the conclusions of law in the PFD which relate to BCBSM's alleged violation of section 402(1)(l) of Act 350 and administrative rule R550.102(4). The ALJ asserts that BCBSM's delay in raising the issue of fraud constituted a violation of section 402(1)(l) and R550.102(4).

Section 402(1)(l) of Act 350 provides:

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

* * *

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

Administrative rule R550.102(4) provides:

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.

The ALJ is correct that BCBSM waited too long to assert a claim of fraud against the Petitioners. Making an untimely legal argument does not constitute a prohibited practice under section 402 of Act 350, nor is it a violation of administrative rule R550.102(4). The appropriate remedy for BCBSM's delay is to reject the fraud claim as untimely. The cited statute and administrative rule are intended to provide a remedy for an untimely claim payment. This dispute concerns the propriety of BCBSM audit findings. Whether the Commissioner supports or rejects the audit findings, BCBSM's audit is permitted under the provider agreement.

IV. ORDER

It is ordered that:

1. BCBSM may not recover the funds it sought from Contemporary Imaging Associates.
2. BCBSM did not violate section 402(1)(l) of Act 350 administrative rule R550.102(4).



R. Kevin Clinton
Commissioner

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

In the matter of	Docket No. 2011-1464
Contemporary Imaging Associates, Petitioner	Agency No. 11-848-BC
v	Agency: Office of Financial & Insurance Regulation
Blue Cross Blue Shield of Michigan, Respondent	Case Type: Appeal Subscriber/Provider

Issued and entered
this 9th day of February, 2012
by C. David Jones
Administrative Law Judge

**PROPOSAL FOR DECISION BASED ON
MOTION FOR SUMMARY DECISION**

Procedural History

This case involved Blue Cross Blue Shield of Michigan's request for refund of alleged overpayments in the amount of \$178,113.30 made to Contemporary Imaging Associates from October 7, 2004 to December 31, 2005, and discovered in a post-payment audit.

The parties exhausted their rights to administrative review under 1986 AACS R 550.101-108. On August 9, 2011, the Commissioner's Designee issued her Review and Determination, finding in favor of Contemporary Imaging Associates.

On or about October 10, 2011, Blue Cross Blue Shield filed its Petition for Contested Case Hearing. On October 19, 2011, the Special Deputy Commissioner issued his Order Referring Complaint for Hearing and Order to Respond. On or about October 19, 2011, the Office of Financial and Insurance Regulation issued a Complaint.

On October 26, 2011, Notice of Hearing was mailed to the parties, scheduling the hearing to commence on December 8, 2011, at 9:00 a.m., at 611 W. Ottawa St., Lansing, Michigan.

On November 10, 2011, an Answer to the Petition for Contested Case Hearing was received from Contemporary Imaging.

On November 14, 2011 an Order Adjourning Hearing and Scheduling Telephone Prehearing Conference was issued, scheduling the conference for December 8, 2011.

On December 8, 2011, a telephone pre-hearing conference was held. Attorney Keith Soltis represented Contemporary Imaging Associates. Attorney Bryant Greene represented Blue Cross Blue Shield of Michigan. Mr. Soltis argued that Blue Cross' claim was barred by the general two-year limitation in the Participation Agreement and the fraud exception did not apply, and requested an opportunity to file a motion. A briefing schedule, with a date for oral argument (February 1, 2012) was agreed upon.

On December 12, 2011, A Summary of Prehearing Conference and Notice of Motion hearing was issued.

On January 6, 2012, Mr. Soltis' Motion and Brief were received. On January 17, 2012, Mr. Greene's Answer and Brief were received. On January 20, 2012, Mr. Soltis' Motion to File a Reply Brief, with Reply Brief was received. Mr. Greene filed no objection to the Reply Brief, and it was accepted.

On February 1, 2012, oral argument on the motion was held. Attorney Keith Soltis represented Contemporary Imaging Associates. Attorney Bryant Greene

represented Blue Cross Blue Shield.

No testimony was taken, however, counsel stipulated to the admission into the record of the following exhibits:

Joint Exhibit 1:	October 6, 2006 Letter from Blue Cross;
Joint Exhibit 2:	April 18, 2008 Letter from Blue Cross;
Joint Exhibit 3:	June 9, 2008 Letter from Blue Cross;
Joint Exhibit 4:	March 13, 2009 Letter from Blue Cross;
Joint Exhibit 5:	Participation Agreement, Addendum H.

ISSUES AND APPLICABLE LAW

The applicable law in this case is MCL 550.1101-1704; and 1986 AACS, R 550.101-108. The authority to hold a contested case hearing is found at MCL 550.1404(6), and 1986 AACS, R 500.107(3).

The issue in this case is as follows:

Is Petitioner entitled to a Summary Decision because Respondent is time-barred from recovery of the alleged overpayment under Addendum H, of the Participation Agreement; MCL 550.1402(1)(l); and 1986 AACS, R 550.102(4)?

FINDINGS OF FACT

1. Addendum H, Participation Agreement provides in relevant part:

BCBSM shall have the right to initiate recovery of amounts paid for services up to two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

2. On October 6, 2006, Respondent sent Petitioner a letter. The letter indicated that the "preliminary results" of an audit identified a minimum overpayment of \$207,786.34 for the audit period of April 1, 2004 to December 31, 2005. The letter gave explanations for Respondent's conclusion of overpayment (insufficient documentation, lack of documentation, lack of orders, and documentation not reflecting the need for

level of service). However, the letter did not claim Petitioner had committed fraud.

3. The October 6, 2006 letter stated that it constituted an "initiation of recovery of this amount." However, the letter did not request Petitioner pay any amount, stated that the review was not yet completed, said Petitioner would be notified of the final details regarding repayment and of Petitioner's appeal rights. The letter requested that in the meantime Petitioner "initiate appropriate corrective actions."

4. On April 18, 2008 Respondent sent Petitioner the next letter on this issue. The letter indicated that the results of the audit identified the actual overpayment of \$191,473.12 for the audit period of October 7, 2004 to December 31, 2005. The letter indicated that services from April 1, 2004 through October 6, 2004 were beyond the two-year recovery period and monetary recovery in the amount of \$10,076.42 was not being requested for that period. The letter gave explanations for Respondent's conclusion of overpayment (the same as in the October 6, 2006 letter, with the addition of services which were not a benefit based on the subscriber's contract and/or BCBSM medical policy). The letter did not claim Petitioner had committed fraud.

5. The April 18, 2008 letter requested repayment of \$191,473.12, and explained Petitioner's appeal rights.

6. On or about May 12, 2008, Petitioner submitted a written complaint to Respondent. On June 9, 2008, Respondent sent Petitioner a letter, declining to reduce the amount of overpayment, and informing Petitioner of the right to request a managerial conference. The letter did not claim Petitioner had committed fraud.

7. A managerial level conference was held on December 22, 2008. On March 13, 2009, Respondent sent Petitioner a letter, which summarized the

conference, revised the overpayment downward to \$178,113.30 and informed Petitioner of appeal rights. The letter did not claim Petitioner committed fraud.

8. On July 9, 2009, Petitioner appealed to the Commissioner for a Review and Determination. At no time before this did Respondent claim Petitioner had committed fraud.

9. However, Respondent did raise the issue of possible fraud at the Review and Determination level. The Commissioner's Designee decided that Respondent had not found fraud, and Respondent had violated MCL 550.1402(1)(l).

CONCLUSIONS OF LAW

A. Summary Decision

Petitioner has moved for a summary decision under 1983 AACRS, R 500.2111(c), which provides as follows:

A party may move for a summary decision in the party's favor upon any one of the following grounds: . . .

(c) There is no genuine issue as to any material fact, and the moving party is therefore entitled to a decision in that party's favor as a matter of law.

On the time-bar issue, which Petitioner raised in its motion, there is no genuine issue as to any material fact. The parties stipulated to admission of five joint exhibits into the record to clarify what the undisputed facts are. My Findings of Fact are based on these exhibits.

B. Initiation of Recovery: Nonfraud

Respondent seeks to recover amounts paid for services from October 7, 2004 to December 31, 2005. Except for instances of fraud (dealt with below), Respondent only has the right to initiate recovery up to two years from the date of

payment under the Participation Agreement, Addendum H (Joint Exhibit 5). Respondent has claimed that it initiated recovery in its October 6, 2006 letter (Joint Exhibit 1), and if true, then the recovery is not time barred. Petitioner claimed Respondent did not initiate recovery until Respondent's April 18, 2008 letter (Joint Exhibit 2), and if so, then the recovery is time barred.

I find that Respondent did not initiate recovery until the April 18, 2008 letter, and therefore the recovery is time-barred. I find this for the following reasons:

1. Although the October 6, 2006 letter claims to constitute an initiation of recovery, the mere claim is not dispositive. The question is whether the letter is truly an initiation of recovery.

2. While the April 18, 2008 letter did request repayment, the October 6, 2006 letter did not request any repayment. A party can not be said to initiate recovery when it does not request any recovery.

3. The October 6, 2006 letter merely informed the Petitioner of the "preliminary results" of an audit, and estimated the amount of overpayment. At that time it wasn't known for sure how much, if any, overpayment was truly made. Under these circumstances it would have been unreasonable for Respondent to request, or for Petitioner to make recovery. In fact, when Respondent sent Petitioner the final results on April 18, 2008, Respondent had made many changes to the "preliminary results."

4. 1986 AACS R 550.102(4) provides in relevant part as follows:

(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.

If the October 6, 2006 letter was really an initiation of recovery (or refusal to pay), it was defective. It did not notify the provider of the right to request a private informal managerial-level conference. Therefore, Respondent may not rely on it.

C. Initiation of Recovery: Fraud

Respondent has argued that this is an instance of fraud because of a pattern of improper billing by Petitioner so there is no time limit on recovery under the Participation Agreement, Addendum H (fraud exemption). Petitioner argued essentially that Respondent may not rely on fraud because Respondent did not timely raise the issue.

The two relevant legal authorities are 1986 AACRS, R 550.102(4), quoted above, and MCL 550.1402(1)(l), quoted below.

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

I find that Respondent did not timely raise the issue of fraud. Therefore, I further find that Respondent may not rely on the fraud exception to the two-year limit in the Participation Agreement, Addendum H.

Respondent did not specifically allege fraud until some date after Petitioner's July 9, 2009 appeal to the Commissioner. This was about one year, three months after Respondent had initiated recovery in its April 18, 2008 letter.

Because of this delay, Respondent violated MCL 550.1402(1)(I). Respondent did not promptly provide a reasonable explanation of one basis of denial (fraud).

Because of the delay, Respondent also violated 1986 AACS R 550.102(4). As noted above, that required Respondent "at the time of a refusal to pay" to provide a "clear, concise, and specific explanation of all the reasons for the refusal." The "refusal to pay" occurred on April 18, 2008 when Respondent sent Petitioner the letter requesting repayment. No where in that letter did Respondent list as a reason for refusal any claim of fraud.

Respondent's Brief, page 5, contains the following statement:

As early as May 2006, BCBSM provided Petitioner with notification of his improper billing pattern. BCBSM's notification included a detailed listing of services that BCBSM noted as not payable. And while the word "fraud" was not used in this letter a pattern of billing outside established BCBSM documentation guidelines for 18 months was found. Based on the findings in *People of the State of Michigan v Gabriel Sagun Orzame*⁶, a consistent pattern of billing outside of the established BCBSM policies that Petitioner had access to may be enough to establish fraud.

At oral argument, Respondent's counsel agreed that this was essentially an argument that Respondent did notify Petitioner of its claim of fraud because fraud can be inferred from a pattern of billing outside policies.

However, an explanation (fraud) raised by inference does not satisfy the law. An inference is not a "reasonable explanation" under MCL 550.1402(1)(I). It is also not a "clear, concise and specific explanation of all the reasons for the refusal", under 1986 AACS, R 550.102(4).

PROPOSED DECISION

Based on the above, I recommend the following decision:

1. Petitioner's Motion for Summary Decision is granted. Petitioner is entitled to a decision in its favor as a matter of law.
2. Respondent violated MCL 550.1402(1)(l) and 1986 AACSR 550.102(4), and initiated recovery too late under Addendum H of the Participation Agreement.
3. Respondent is not entitled to pursue recovery of the alleged overpayment from Petitioner.

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 the issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after Exceptions are filed.


C. David Jones
Administrative Law Judge