**Business Ethics and BlueCross BlueShield of Alabama:
Observations of a Customer**[Rick Garlikov](http://www.garlikov.com/writings.htm)

Through my wife’s employment in public education, we have had BlueCross BlueShield of Alabama as our health insurance provider for nearly 40 years. For major illnesses and injuries involving hospital inpatient care and emergency room treatment, they have been excellent in paying medical charges so far, though there is something obviously odd, and probably ethically so, about the standard sort of situation in the entire medical care billing/insurance industry where something like $60 from the insurance company pays “in full” a hospital, doctor, or lab charge of $375, or where comparably small percentage payments pay for significantly larger amounts charged by hospitals. But that is difficult to tell whether the fault lies with gouging, overcharging service providers or underpaying, bullying insurers or a combination of both in some sort of evolved game played on patients and customers to make providers seem reasonable and compassionate and insurers seem economical stewards of customer premiums.[[1]](#footnote-1) The antagonistic symbiotic marriage between the business departments of medical centers and insurers is likely a gold mine(field) of ethical issues, but that is not what I am writing about here.

The areas of ethics I am concerned about are BlueCross BlueShield of Alabama’s policies and practices in 1) unexpectedly denying claims for treatments or procedures of two sorts which seem to meet the letter of the contract and the spirit of reasonable medical care that would be covered by the philosophy of the policy – this shakes confidence in one’s coverage, and 2) their unfair and unreasonable appeals process that is neither transparent nor explanatory enough to be helpful to the customer, and which give every appearance to be merely a rubber stamp of the original denials, despite the company’s claim to the contrary. This appeals prevents the customer from finding out whether there is some simple error made in the medical care provider’s submission code or whether there is some more serious medical care or insurance plan coverage that the customer needs to be able to address.

The two forms of denials with which I am familiar are the denials of payment for:

1) treatments which can be described or characterized in different categories or terms – one of which clearly meets the language and spirit of what is covered in the contract, but the other of which would not meet the language of the contract (but only because of some coincidental characteristic that would not be relevant in normal understanding). (I will explain and give actual case examples shortly, but the analogy here is like having an auto insurance claim denied because although your auto insurance policy covers car accident repairs, it does not expressly cover the repair of blue objects and your car is blue. And when you appeal saying that your car was in an accident, and they cover car accidents, they respond that you want them to pay for the repair of a blue object, and nothing in your policy says they will pay for the repair of blue objects.)

2) treatments which they claim are not medically necessary, under a very narrow, unusual, and limited meaning of “necessary” and/or of what counts as evidence for being medically necessary.

The problem with the appeal process is that 1) it is closed to the appellant who cannot tell whether the evidence the appellant has submitted is being presented to the review panel at all, or presented in a way that explains the problem perceived with the original claim denial, 2) there is no dialogue with the customer to ascertain whether there is even mutual understanding what the medical treatment is for, which can be a serious problem if it is accidentally miscoded or incompletely explained in the original filing for payment, and 3) the explanation of the review panel in denying the appeal either just repeats the judgment that was being appealed or at most gives an additional explanation that makes no (more) sense. There is no dialogue allowed that would give even the appearance of understanding what the appellant is claiming or questioning, or that would demonstrate a good faith attempt is being made to resolve the disagreement or answer the questions being asked in some reasonable way. Instead the appearance is that they think their doctors are more knowledgeable than yours about what is reasonable medical care, even though they say otherwise, and that if you find any fault with their explanations, it is a problem with your understanding or limited knowledge of either medicine or English.

They seem to have a conflict between contractual legalism combined with sophistry on the one hand, and ethical fairness and understanding on the other, with the legalistic side currently dominant. But the combined goal of making sufficient profit after legal fees and court costs while avoiding personal jail time by company executives is not the highest standard of ethical aspirations in business.

If their practices actually and intentionally commit these faults instead of simply giving the appearance of doing so, then they are clearly ethically wrong because they are not being fair to the customer nor honoring the contract, and they are harming the customer financially. If their practices merely give this appearance but do not actually commit the faults (which is difficult to imagine), it is still wrong because it causes the customer unnecessary, understandable, and obvious distress.

Some specific instances:

I first noticed one of their problematic standard practices in 1981 when my wife was pregnant with our first child. The amount of money involved was small, and not worth making an issue about other than to verbally question the decision with a customer service representative. Prescription drugs were covered by the policy, and at that time maternity vitamins were prescription drugs. However, BlueCross BlueShield of Alabama denied the claims for them because, as the customer service representative stated and thus “explained”, they said they were “food supplements” and that food supplements were not covered under the policy. The policy did not say food supplements were exclusions for prescription drugs, however. BlueCross BlueShield of Alabama simply ruled by fiat that because maternity vitamins were also able to be considered to be, or called, food supplements, they were not counted as prescription drugs, even though they were chemically manufactured items that required a prescription to purchase (i.e., prescription drugs). So basically, BlueCross Blue Shield could interpret their policy terms as they wished, and if a treatment could be described in terms that did not fit the policy, besides the terms under which they usually would be described which did fit the policy, the company recognized only the terms that did not meet the policy. Ten years later they paid me for these vitamins when I complained to them about a bigger example of this kind of abuse of the English language, and cited this vitamin case as an example. They did not pay for the bigger claim, but seem to have wanted to deny or eliminate evidence of the pattern.

In that later case, my younger daughter needed maxillary expansion – a widening of her upper jaw to remedy a severe under bite (her upper jaw extended out forward further than her lower jaw, and it was noticeable by her teeth and bite not lining up, by about a half inch difference or so). This apparently can cause serious medical problems later in life and medically is advised to be remedied before then as a preventive procedure. If this were to be fixed surgically in a major operation around age 16, BlueCross BlueShield would pay for that, but not if we had it remedied when my daughter was around age 7 using a much less draconian and entirely non-invasive mechanical procedure that forced her jaw apart by essentially splitting it apart along the middle line before the bones of both sides fused together there. A small device with a screw of the sort used in a car jack was fitted across her palate, attached to two teeth on each side of her upper jaw. Each morning, as directed, I turned the screw a quarter turn that lengthened the device a very tiny fraction, pushing the sides of her upper jaw, and thus skull, apart incrementally (as a car jack pushes the car off the ground a small distance with each turn of the crank). One day, the upper jaw made a noticeable popping sound during this process, but it did not hurt my daughter. We had been told this would occur as planned, and, as directed, I continued widening the device for another week or two, as I recall. Then the device was easily removed. That remedied the under bite, and at age 28 now, she has had no issue with that since. It sounds like an awful process, but there was no pain or discomfort for my daughter and it only took a minute or less each morning to do. It was more funny and strange than anything else. My biggest concern was not dropping the little turning crank down her throat, and I had tied a long string to it to prevent that from happening if I accidentally dropped it.

BlueCross BlueShield of Alabama would not pay for the procedure, because they said it was orthodontic “**because** it moved her teeth”. It is true that the procedure was done by an orthodontist, but it was not orthodontics in the sense of realigning her teeth relative to each other or in their sockets. It was not straightening her teeth or spacing them differently relative to each other. As I told them in a follow-up to a denied appeal for which I supplied them the technical medical details of the procedure as they asked for, their claim that it was orthodontics because teeth moved was tantamount to saying that a person with paralysis of his hand was not really paralyzed because he could move his fingers by bending his elbow. My daughter’s skull was separated along the medial line, and her teeth moved with that, together; the teeth did not move separately from her jaw bone any more than your teeth “move” orthodontically when you talk or eat or turn your head. This was a medical procedure done non-surgically in order to prevent the need for surgery to correct it later, surgery for which they would have paid.

Because they could describe this as “moving teeth”, even though it also altered the skull, they denied paying for the treatment. When I told the customer service representative this was the same semantic tactic they used in denying payment for the maternity vitamins for both pregnancies eight and ten years earlier, she said the maternity vitamins should have been covered as prescription drugs. But she said the company did not keep paper records that far back and they were not on computer, so she could not have the claims paid now. I pointed out, to her clear surprise, that I still had the record of their denials of the claim, and when I sent her a photocopy of them at her request they then paid the reimbursement.

But at that time for the maxillary expansion treatment, the only recourse was to file an appeal with BlueCross BlueShield of Alabama. The way that worked at the time was to send them medical research information about the procedure -- its description, detailed explanation, purpose, and its necessity and efficacy, etc. and a panel of their doctors decided the appeal claim. The evidence you send, and any cover letter with further information or support of your contention was all said to be presented to the panel, without your being allowed to be there, by the person who had denied your original claim. In other words this is a closed panel review with their (presumably paid) experts and your side is presented (or allegedly presented) to them by the person whose judgment you are appealing. It was a total surprise, of course, when they reached the same conclusion and gave the same reason as was given originally – it was not a medical procedure but an orthodontic one “because teeth were moved” [sarcasm mine].

[Notice, if they had excluded this (not uncommon) treatment from their policy, I would likely have been upset that the policy did that, but would not have been able to challenge their denial. Also, notice there are two different issues here about the “moving of teeth”, one more ethically important than the other. The less important one to me, though more important probably to an attorney, is the legalistic, semantic issue of what it means for “teeth to be moved”. If Blue Cross wanted to pin their denial on the claim teeth were moved and that this is what made it an orthodontic treatment, then that was a semantic stretch on their part, not mine. The more important issue however is whether this is in any real sense a medical treatment or an orthodontic realignment of teeth – whether this is about repositioning her teeth or repositioning her upper jaw and skull. Clearly it is about her skull and upper jaw. And the fact they do it via a device attached to her teeth rather than through surgically sawing her skull apart does not make it orthodontic any more than inserting a cardiac device through a blood vessel in the leg is leg surgery.]

I wrote the company that their “customer service” needed work, because there was no real ability to have a discussion with anyone who made decisions, just one way conversations with those who could only read the decisions to you, and because the people who made the decisions didn’t seem to be paying attention to the evidence presented to them, if it was presented at all or in any manner that was fair. The review of the appeal was simply a black box in which all input gave the same output, and you couldn’t see what was happening inside; and the output made no sense, and no more sense than the original explanation for the denial that it repeated. That is not “customer service”. And it is not a fair or reasonable appeals process or procedure.

But nothing has changed in the twenty years since then. In May of this year, I am told by doctors that I had a stroke, though the only evidence of that was 1) impaired ability for about fifteen minutes to say some words while otherwise speaking okay, 2) a subsequent MRI, and 3) what seems to me to be an improvement in some of my verbal skills. The MRI gave evidence the stroke was caused by a clot stemming from my heart, and a battery of standard post-stroke cardiac and vascular tests were done to find the source of the problem. They were all negative.

My doctor sent me to a neurology stroke expert at a major medical center. He explained, what I have since learned is somewhat well known by physicians, that AFib (atrial fibrillation) is a potential cause of strokes when no other cardiovascular cause is apparent, and it should be discovered and treated with a blood thinner if the condition exists, reducing the chance of a subsequent stroke by 66%, according to the research. He pointed out that a standard office electrocardiogram would not likely detect intermittent AFib and that a monitor needed to be worn for a month to find out for sure. I wore such a monitor 24/7 for the month. It transmitted telemetric cardiac data by a companion cellular device. The monitoring company billed BlueCross BlueShield of Alabama $3800. Insurance companies normally pay about $800 and the monitoring company considers that payment in full, so there again is one of those seemingly standard billing peculiarities. In essence, BlueCross BlueShield of Alabama was refusing to pay $800 for a test given to help prevent a stroke in a patient who already had one and who therefore has a higher probability than normal of having a subsequent one.

But in this case BlueCross did not pay at all and instead denied the payment for the claim; the monitoring company billed me then for the $800, and was willing to wait for the results of my appeal with BlueCross, but knowing BlueCross’s propensity for sloth in this sort of thing[[2]](#footnote-2), I paid the company the $800, so they didn’t have to wait to be paid for services they had provided me. (The monitoring showed no abnormalities with my heart beat.)

The BlueCross customer service representative I spoke with first, at that point, said that if the doctor sends them citations of peer reviewed journal research articles that showed cardiac monitoring was indicated for stroke, they would pay the claim. The doctor says he sent them such citations; they said they received them, but didn’t change their decision and still said the procedure was not covered. The notes in my file, according to this customer service representative said the panel said the procedure was “investigatory” and thus not covered, though the physician said the peer reviewed evidence makes it long past “investigatory” or “experimental”.

Rather than trying to file another appeal with BIueCross (if they allowed that, which I am not sure) and doing this dance again, I filed a complaint with the state insurance commission and BlueCross BlueShield of Alabama sent me a response again saying “based on our additional review, our medical staff has determined that your condition does not meet medical criteria for coverage based on review of the medical records and Blue Cross and Blue Shield of Alabama’s Medical Policy #460. [which they sent, and which seems not to match what they say] Based on our review, outpatient cardiac telemetry does not meet coverage criteria as a diagnostic alternative in patients who experience infrequent symptoms (suggestive of cardiac arrhythmias).” Apparently a single stroke isn’t “frequent enough symptoms” to warrant this. “We hope this information is helpful. Sincerely, Customer Service”.

Seriously, not even a person’s name; just signed “Customer Service” – no individual you can call to follow up about the case. Instead you have to go through “customer service” with a different representative who just pulls up the file and reads you what you already know they said. So what they had sent me was a long policy paper giving an analysis about the medical efficacy and indications and differences about remote telemetric cardiac monitoring with the conclusion given not to pay anything for ones that are more expensive than others or other kind of cardiac monitoring, a short sentence that repeats the denial of coverage and payment for the claim, and a note they hope that this [‘customer service’] information is helpful. No one reasonable would find that “helpful” or “service”. No one reasonable would consider it an explanation or a meaningful one. No one reasonable would consider it a sincere attempt to provide health insurance coverage to pay for medically indicated health care in an important condition (stroke). And no one would consider it not making medical decisions contrary to a specialist’s medical knowledge and judgment about a patient’s condition.

Moreover, I see nothing in the seven page policy document they sent that explains why the cardiac monitoring used does not meet their criteria other than possibly that it is more costly than other effective monitoring, though when I called to find out what sort of monitoring they would have paid for, they would not answer that, and said the doctor would have to file a code and they would then accept or reject it. But they won’t say what counts because “that would be telling your doctor what treatments to use, and we don’t do that”. I pointed out their letter says they only make payment decisions, not medical ones, and that their policy implies some cardiac monitoring procedures are covered, and I was asking which ones were or how the doctor is supposed to know what is covered or not. The customer service representative says the doctor has to file a code and they will approve payment or not. [Apparently BlueCross employees are hired or retained on the basis of thinking that repeating a point explains it.] I pointed out that trial and error seems to be somewhat silly in this matter, and they should be able to say what form of cardiac monitoring would qualify for payment under the contract. That conversation went nowhere, of course, because she is not authorized or knowledgeable enough to respond and cannot connect me to anyone who is. It is “customer service” in name only (or in the animal husbandry sense of ‘service’), as was their sending me as a response to my complaint with the state insurance commission a letter that simply repeated their past denials that the test was medically indicated, despite evidence and the physician’s protest to the contrary that the test was medically indicated.

Specifically they wrote in their policy:

“Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members’ contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.”

And yet, their letter said, as I pointed out above, “based on our additional review, our **medical staff** has determined that your **condition** does not meet **medical criteria** for coverage based on review of the **medical records** ... and **Medical Policy** #460”. [Emphasis mine.] How is it not hypocritical at worst or inconsistent at best to have their “medical staff” determine what “medical criteria” are appropriate for which medical “condition” a patient has and yet claim they are not making medical decisions, and are providing health care insurance!

What if we told the executives and midlevel management and attorneys at BlueCross BlueShield of Alabama the following:

We will pay you your full salaries, as contracted, but under the following conditions:

1) You do the work that in your professional opinion and best judgment is what you need to do.

2) You do it in the way you think will be right and best.

3) We won’t tell you what you should be doing or how to do it.

4) However, at end of a few weeks, we will tell you whether we will pay you for that previous day’s work or not.

5) If you want to know ahead of time whether the work you intend to do will be paid or not, we will tell you if you explain to us what you want/plan to do.

6) To save us time, just use one of the thousands of code numbers we have for every possible business plan.

7) We will answer whether it will be paid or not.

8) If it won’t be paid, you will have to submit a different plan (code) to see whether we will pay it.

9) We won’t tell you what we will pay for other than to accept a proposal you make which we find acceptable, but we won’t infringe on your professional judgment by telling you ahead of time what we will find acceptable. You have to tell us what you want/plan to do.

10) In doing this, we are not questioning your professional judgment; we are only telling you what we will pay you for. We are not going to tell you how to do your job.

11) If at any time you disagree with our decisions, you may appeal the rejection in writing and turn it in to us and we will present your argument to our independent review panel and they will decide whether we were wrong in rejecting paying you or not. They are managers in businesses like this too, and they know what is professionally feasible in regard to what we will pay for. You cannot be present at that meeting, but we will present your argument fairly, accurately, and completely. Trust us.

12) But this panel will not make any judgments about the correctness of what you did. They will not base their decision on whether what you did was good or not, just on whether it met our guidelines, which are here to pay for proper work.

13) In order to help you understand what work we will pay for and what work we won’t pay for, we have online dozens of pages of rules and regulations along with thousands of pages of facts about different kinds of tasks, and some of those facts will be potentially relevant to the decision we will make. We hope that will be helpful to you.

Surely there is no reason they would want to work elsewhere, even if there is no other place to work.

I understand that providing health insurance does not mean covering questionable medical procedures, tests, etc., but that does not seem what is at issue in their policy #460. They seem to indicate in that policy that cardiac monitoring, including “Mobile Cardiac Outpatient Telemetry” (MCOT) monitoring, does detect arrhythmias related to stroke, but that remote telemetric cardiac monitoring is not the least expensive method for doing so and is thus not covered. What they won’t answer is what/which cardiac monitoring is covered under the policy and they won’t answer why they wouldn’t pay at least the amount they would have paid for that. It makes sense they wouldn’t pay for a more expensive procedure than is necessary and effective, but it doesn’t make sense they wouldn’t pay at least the amount they would have paid for the less expensive effective procedure.

In short, they seem to deny coverage based on nonsensical explanations and then have an opaque “appeal and review” system that is at worst a sham and at most a rubber stamp, and which does not give any more reason for rejection of coverage than was given for the original denial, in spite of professional evidence presented that shows the original denial to be falsely unfounded. That seems to be unethical in showing disregard for the truth, the customer, the customer’s well-being, the spirit of an agreement that sells “health care insurance coverage for treatment by qualified physicians”, and for transparency and fairness, in those kinds of cases they are likely to be able to get away with legally and financially.

1. My younger daughter, during a road trip caught the very tip of one of her fingers in the car door she shut as we were returning home. We were outside a Stuckey’s restaurant, and they gave us ice in a cup for her finger. Later, at an emergency room to see whether her finger needed further attention, we were told after a brief cursory observation “no, it just needs ice”. The emergency room provided ice and then charged $75 for it and $200 for the visit. Apparently their ice was much more valuable than Stuckey’s ice. I called the insurance company and futilely begged them **not** to pay. I did not think that was a valid use of insurance premiums, so it is not that I think that paying all claims is right or what makes an insurance company ethical. [↑](#footnote-ref-1)
2. and a month later they still had not responded, and I had to call them, and they said they had misfiled it but would tend to it now; and then I had to call three weeks later to find they had rejected the appeal. Of course when I filed a complaint with the Alabama state insurance commission, BlueCross Blue Shield of Alabama responded within the required ten days, even though the response was what I describe in the body of the essay and was still an unexplained rejection of the claim, though they call it an explanation. [↑](#footnote-ref-2)