STATE OF MICHIGAN

COURT OF APPEALS

MICHIGAN AFFILIATED HEALTHCARE SYSTEMS, INC., f/k/a LANSING GENERAL HOSPITAL, d/b/a MICHIGAN CAPITAL MEDICAL CENTER,

Plaintiff-Appellant,

v

PEOPLES LIFE INSURANCE COMPANY and STOP LOSS INTERNATIONAL CORPORATION,

Defendants-Appellees,

and

CC SYSTEMS CORPORATION OF MICHIGAN,

Defendant.

UNPUBLISHED
November 27, 2001

No. 225067
Ingham Circuit Court
LC No. 94-077781-CK

Before: O'Connell, P.J., and Sawyer and Smolenski, JJ.

PER CURIAM.

The trial court denied plaintiff's motion for summary disposition and granted defendants' motion. Thereafter, the remaining issues in this case, which are not relevant to this appeal, were disposed of and the trial court entered a final judgment. Plaintiff now appeals and we reverse and remand.

This case involves an issue of coverage under a Reinsurance Agreement. Plaintiff does business in Lansing under the name Michigan Capital Medical Center and was formerly known as Lansing General Hospital. At the time relevant to this appeal, plaintiff was self-insured for employee health coverage, with a Reinsurance Agreement with defendants covering expenses over $60,000 per person. The policy at issue here was effective January 1, 1992.

One of the employees covered under the plan was Carol Hoskins, a nurse at Lansing General. Hoskins was originally diagnosed with breast cancer in 1987 and underwent a

lumpectomy followed by radiation therapy. In March 1992, she was diagnosed with Stage IV metastatic breast cancer, an advanced form of breast cancer. She sought treatment recommendations from two out-of-state medical facilities, M.D. Anderson in Houston and Allegheny General Hospital in Pittsburgh. Physicians at both facilities recommended an autologous bone marrow transplant with high dose chemotherapy (ABMT/HDC) as her only chance of survival. This procedure involves removal and retention of the patient's bone marrow. This is followed by high dose chemotherapy (which is administered at levels which damages bone marrow). Thereafter, the patient's bone marrow is returned when the toxicity level from the chemotherapy has sufficiently abated. The cost of the procedure in 1992 was between $150,000 and $200,000.

Before undergoing treatment, Hoskins sought a pre-determination of coverage under the plan. Plaintiff's benefits administrator, defendant CCS, initially denied coverage. Ultimately, however, plaintiff determined that the plan did, in fact, cover the treatment. Lansing General made arrangements with Allegheny General Hospital for the procedure.

Plaintiff sought coverage under the Reinsurance Agreement, which defendants denied. Plaintiff thereafter filed suit. The claims against the benefits administrator, CCS, were separately resolved in the trial court and are not at issue in this appeal.

Plaintiff first argues that the trial court erred in granting summary disposition to defendants on plaintiff's breach of contract claim and that summary disposition should have been in plaintiff's favor. We agree.

Plaintiff presents a multi-prong argument in support of the proposition that the trial court erred. We find at least one aspect of plaintiff's argument meritorious. Specifically, plaintiff persuasively argues that language in the Reinsurance Application regarding experimental/investigational treatments differs from that in the Reinsurance Agreement and should control. We agree that, under the language in the Reinsurance Application, plaintiff was entitled to summary disposition.

The Reinsurance Agreement includes the following exclusion:

> Expenses in connection with surgery or treatment classified by the Health Care Financing Administration of the United States Department of Health and Human Services as "experimental", "investigational" or as "not reasonable" or "necessary".

The Health Care Financing Administration is Medicare. This case could presumably be easily resolved by determining how Medicare classifies ABMT/HDC. However, both parties have produced documents that suggest Medicare's treatment of ABMT/HDC is favorable to their positions. Defendant relies upon a Medicare Coverage Issues Manual, referring to a version which it claims was published in the Federal Register on June 11, 1992, citing 57 Fed Reg 24797, 24804, with the following provisions:

C. Autologous Bone Marrow Transplantation (Effective for Services Performed on or After 04/28/89).—Autologous bone marrow transplantation is a technique for restoring bone marrow stem cells using the patient's own previously stored marrow.

* * *

2. Noncovered Conditions.—Insufficient data exist to establish definite conclusions regarding the efficacy of autologous bone marrow transplantation for the following conditions:

- Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);
- Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11); or
- Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0-199.1).

In these cases, autologous bone marrow transplantation is not considered reasonable and necessary within the meaning of §1862(a)(1)(A) of the Act and is not covered under Medicare.

This language, which was relied upon by the trial court in granting summary disposition, certainly seems to support defendants' position. However, plaintiff relied upon another document from Medicare, described as an excerpt from a billing procedures manual:

416.3 Autologous Bone Marrow Transplantation.—

A. General.—Medicare guidelines for coverage (and noncoverage) of autologous bone marrow transplants are more specific and descriptive than those for allogeneic bone marrow transplants. Also, ICD-9-CM coding rules changed on October 1, 1991. Therefore, different claims processing requirements apply for discharges before and after October 1, 1991. Procedure code 41.01, autologous bone marrow transplant, may be covered if one or more of the following diagnosis codes are present:

* * *

The following conditions are specified by Medicare as noncovered for autologous bone marrow transplants:

Diagnosis Codes	Description
204.0, 205.0	Acute leukemia in relapse
206.0, 208.0	Acute leukemia in relapse
205.1	Chronic granulocytic leukemia
140.0, 199.1	Solid tumors (other than neuroblastoma)

B. Special Coverage.—Effective for services October 1, 1991, the following code changes will apply to autologous bone marrow transplants. Indicate procedure code 41.01 as noncovered only if none of the following codes are present as either a principal or secondary diagnosis.

Diagnosis Codes	Description
140.0 – 1991.1	Solid tumors (other than neuroblastoma)

* * *

Because bone marrow coverage is more specific than the available ICD-9-CM codes, the intermediary's PRO(s) will review all transplants on a postpayment basis. All claims for procedure code 41.01 with diagnoses that pass the MCE noncovered procedures edit as covered will be paid.

The deleted portions in the above quotation merely refer to other, nonrelevant diagnoses.

While these dueling documents create some confusion as to how ABMT/HDC is treated by HCFA under the Medicare program, it is important to note that neither document classifies it as "experimental" or "investigational." Rather, while the document relied upon by defendants classifies it as not "reasonable and necessary" for the treatment of solid tumors because of a lack of a showing of efficacy, it does not classify it as "experimental" or "investigational."

This point would probably not be important if the coverage issue could be resolved only by looking at the document provided by defendants and the provisions of the Reinsurance Agreement. Under the Reinsurance Agreement, coverage is excluded for a treatment classified by the HCFA as " 'not reasonable' or 'necessary'." The document produced by defendants clearly so classifies ABMT/HDC for treatment of solid tumors and, therefore, coverage would be excluded.

However, plaintiff argues that the language in the Reinsurance Application regarding experimental or investigational treatments differs from the exclusion clause in the actual Reinsurance Agreement and that the language in the application should control over that in the agreement. We agree.

The Reinsurance Application states that expenses "in connection with experimental or investigational surgery or treatment not considered reasonable and necessary as so classified by the Health Care Financing Administration of the United States Department of Health and Human Services are not reimbursable expenses under this contract." This is in contrast to the exclusion clause in the actual Reinsurance Agreement which excludes expenses for surgery or treatment where HCFA classifies that surgery or treatment as " 'experimental', 'investigational' or as 'not reasonable' or 'necessary' ".

In other words, under the exclusionary clause of the Reinsurance Application, for a treatment not to be covered, it must be both "experimental or investigational" and "not considered reasonable and necessary" conditions. Further, as mentioned above, the HCFA does

not classify bone marrow transplant as "experimental or investigational." Rather, it declines coverage under Medicare for ABMT/HDC for solid tumors because it has not been adequately shown to be an effective treatment for solid tumors, including breast cancer (again, keep in mind that plaintiff has produced a document which suggests that, at least in some instances, HCFA does provide coverage for ABMT/HDC in solid tumor treatment). Therefore, while defendants may be able to show that ABMT/HDC is not considered "reasonable" or "necessary" by the HCFA for treatment of breast cancer, thus coming within the exclusion under the actual reinsurance policy, it cannot show that it is "experimental or investigational" and, therefore, would not come within the exclusionary language of the Reinsurance Application.

This distinction between the application and the agreement, of course, is material only if the Reinsurance Application is part of the agreement between the parties. Fortunately, that issue is easy to resolve because the first paragraph of the Reinsurance Agreement makes the application part of the parties' agreement:

> This Reinsurance agreement, together with your Application, the Qualification of Application constitutes the agreement you and we have entered for reinsurance. Your Benefit Plan, as described in your Plan Document, is also included as part of the Reinsurance Agreement. Reinsurance coverage under this Reinsurance Agreement is issued in consideration of your Reinsurance Application, the Qualification of the Application, Plan Document, all other supporting facts, data, statistics and documents, and payment of premiums when due.

Thus, the application, and its more favorable exclusion clause, is part of the parties' agreement by the explicit terms of the agreement. Therefore, at a minimum, there exists an ambiguity regarding the two exclusion clauses. Any ambiguity in an insurance contract drafted by an insurer must be resolved against the insurer. *Mays v Ins Co of North America*, 407 Mich 165, 173; 284 NW2d 256 (1979). Accordingly, this Court must apply the provisions of the application regarding the "experimental or investigational" exclusion, which are more favorable to plaintiff.

As previously discussed, ABMT/HDC treatment does not meet the requirements of the exclusion clause within the application. Therefore, the trial court should have found that the coverage for the treatment was not excluded under the reinsurance contract and granted judgment in favor of plaintiff.

While plaintiff presents additional arguments on this issue, our resolution of the matter renders it unnecessary to consider them. Additionally, because we concluded that plaintiff was entitled to summary disposition on the breach of contract claim, it is unnecessary to consider plaintiff's argument that the trial court erred in granting summary disposition to defendant on the misrepresentation and Michigan Consumer Protection Act, MCL 445.901 *et seq.*, claims.

Finally, plaintiff argues that the trial court should be directed to award twelve percent interest on the judgment under MCL 500.2006(4). This issue, however, is premature inasmuch as the trial court has not yet addressed the issue of interest. On remand, the trial court will enter

judgment in plaintiff's favor. If plaintiff does not believe that the trial court included the appropriate interest provisions in that judgment, plaintiff may pursue the appropriate appellate remedies at that time.

Reversed and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction. Plaintiff may tax costs.

/s/ Peter D. O'Connell
/s/ David H. Sawyer
/s/ Michael R. Smolenski