STATE OF MINNESOTA

IN SUPREME COURT

A16-0986

Court of Appeals

Hudson, J.
Took no part, Lillehaug, Chutich, JJ.

James Linn, et al.,

Respondents,

vs.

Filed: January 3, 2018
Office of Appellate Courts

BCBSM, Inc.,

Appellant.

Brandon Schwartz, Michael Schwartz, Schwartz Law Firm, Oakdale, Minnesota, for respondents.

Joel A. Mintzer, Doreen A. Mohs, Michelle Block, BCBSM, Inc., Eagan, Minnesota; and

Mahesha P. Subbaraman, Subbaraman PLLC, Minneapolis, Minnesota, for appellant.

Janet C. Evans, Richard C. Landon, Gray, Plant, Mooty, Mooty & Bennett, P.A., Minneapolis, Minnesota, for amicus curiae Minnesota Council of Health Plans.

S Y L L A B U S

1. An external-review decision under Minn. Stat. § 62Q.73, subd. 7(c) (2016), is an independent determination of medical necessity that creates only a statutory obligation, not a contractual obligation, to pay an insured's claim.

2. Because there is no genuine issue of material fact regarding the type and location of the insured's tumor and the health-plan contract plainly excluded coverage for requested treatment regarding the type and location of the insured's tumor, the district court properly granted summary judgment to the health-plan company.

Reversed.

O P I N I O N

HUDSON, Justice.

In this appeal, we must address the effect of external-review decisions under Minn. Stat. § 62Q.73, subd. 7(c) (2016). Appellant BCBSM, Inc. ("Blue Cross") denied respondent James Linn's insurance claim because the requested treatment was not considered medically necessary under the parties' health-plan contract. After Blue Cross denied the claim, an external-review entity determined that the treatment was, in fact, medically necessary for Linn's condition. Blue Cross then paid the claim, but Linn and his wife sued Blue Cross for breach of contract. The district court granted summary judgment for Blue Cross, concluding that the treatment was not medically necessary under the contract's plain terms and that Blue Cross fulfilled its contractual obligations when it paid for the treatment following the external review. The court of appeals reversed. Because we conclude that (1) external-review decisions are independent determinations of medical necessity that do not supersede contractual definitions of medical necessity, and (2) the health-plan contract plainly excluded coverage for Linn's claim for treatment, we reverse.

FACTS

Blue Cross is a nonprofit corporation, organized under Minnesota Statutes chapter 62C (2016), which contracts with individuals to provide health insurance. James and Gloria Linn purchased an Individual BlueAccess Health Plan Contract ("Contract") from Blue Cross.[1] Under the Contract, Blue Cross agreed to "timely" pay for covered, medically necessary, services. In other words, Blue Cross agreed to pay for medically necessary care that was also covered under the contract; Blue Cross did not agree to pay for *all* medically necessary care. Specific medical policies, which were incorporated into the Contract by reference, defined when particular treatments were considered medically necessary under the Contract. The Contract also notified the Linns of their right to an internal-appeal process and an optional subsequent external-review process, as required by Minn. Stat. § 62Q.73 (2016), in the event that a claim was denied because Blue Cross determined that a requested treatment was not medically necessary.

Under section 62Q.73, if a health-plan company[2] concludes that the treatment is not medically necessary and denies coverage, an insured may request an independent, external review to determine whether the treatment is medically necessary. Minnesota adopted its external-review statute in 1999 after coalitions of patients, providers, and legislators sought to protect patients from unreasonable insurance denials resulting from cost-containment

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[1] The Contract was not subject to the Employee Retirement Income Security Act ("ERISA"). *See* Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2012).

[2] Blue Cross is a "health-plan company" as defined by Minn. Stat. § 62A.01, subd. 4(1) (2016).

methods in managed care, such as utilization reviews and pre-authorization requirements of insureds' care by insurers. Act of May 25, 1999, ch. 239, § 39, 1999 Minn. Laws 1880, 1897–99; *see* Aaron Seth Kesselheim, *What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through A System of External Appeals*, 149 U. Pa. L. Rev. 873, 881–99 (2001). Health-plan companies adopted these cost-containment methods to help stabilize the rising cost of medical care from an overutilization of care. *See* Kesselheim, *supra*, at 885–99. To protect patients, external-review statutes added an independent review process to ensure timely and impartial review of insurance denials. *See* Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 Yale J. Health Pol'y L. & Ethics 93, 121 (2006).

James Linn was diagnosed with chondrosarcoma, a type of bone cancer that affects cartilage, in the thoracic (mid-back) region of his spine. From March 2014 to December 2014, Linn underwent several surgeries to remove the cancer. During the course of his treatment, specialists recommended Proton Beam Radiation Treatment ("PBRT"), which is a form of radiation treatment that can be directed and localized to minimize side effects. Linn's radiation oncologist submitted a letter to Blue Cross to pre-authorize the use of PBRT, arguing that PBRT was medically necessary for Linn. Blue Cross timely denied coverage for PBRT, explaining that under the Contract's medical policy for PBRT, the treatment was only medically necessary when used in the "basisphenoid region" and "cervical spine," not in the thoracic spine—the location of Linn's cancer. Linn's radiation oncologist appealed Blue Cross's denial on Linn's behalf. But Blue Cross again timely denied coverage for the treatment.

After Linn exhausted Blue Cross's internal-appeal process, he requested an external review of Blue Cross's denial under section 62Q.73, subdivision 7(c). The Minnesota Department of Commerce referred the request to the MAXIMUS Center for Health Dispute Resolution, a private company that contracts with the State to conduct external reviews. MAXIMUS determined that PBRT was medically necessary for Linn. Consequently, Blue Cross paid for Linn's PBRT, and Linn received seven weeks of PBRT.

Despite eventually receiving coverage for PBRT, Linn and his wife sued Blue Cross for breach of contract and other claims. The Linns argued that Blue Cross breached the Contract by initially denying payment for a treatment (PBRT) covered under the Contract as medically necessary care. The Linns claimed that surgery would have been unnecessary had Blue Cross approved their initial request for PBRT. On cross-motions for summary judgment, the district court granted summary judgment for Blue Cross. The district court rejected the Linns' interpretation of the medical policy governing PBRT and concluded that (1) the plain language of the Contract excluded coverage of PBRT for chondrosarcoma on the thoracic spine and (2) Blue Cross provided "timely" care under the Contract because Blue Cross paid the claim after the external-review decision.

The court of appeals reversed and remanded to the district court. *Linn v. BCBSM, Inc.*, 890 N.W.2d 160, 162 (Minn. App. 2017). The court of appeals held that because the external-review decision "binds the insurer with respect to medical necessity, the district court erred by interpreting" the meaning of medical necessity in the health-plan Contract. *Id.* In other words, the court of appeals concluded that the external-review decision was a binding decision on the medical necessity of the treatment under the Contract, not just a

decision obligating Blue Cross to pay the claim. The court of appeals remanded to the district court to further consider whether Blue Cross breached the "timeliness" provision of the Contract and caused compensable damages to the Linns. *Id.* Blue Cross appealed, and we granted review.

ANALYSIS

On appeal from summary judgment, we review de novo "whether there are any genuine issues of material fact and whether the district court erred in its application of the law to the facts." *Commerce Bank v. W. Bend Mut. Ins. Co.*, 870 N.W.2d 770, 773 (Minn. 2015); *see also* Minn. R. Civ. P. 56.03. We therefore review de novo the district court's interpretation of (1) Minnesota's external-review statute and (2) the parties' health-plan Contract. *See Christianson v. Henke*, 831 N.W.2d 532, 535 (Minn. 2013) (stating that we review statutory interpretation questions de novo); *Bus. Bank v. Hanson*, 769 N.W.2d 285, 288 (Minn. 2009) (stating that we review contract interpretation questions de novo).

I.

We first consider the role of the external-review process and the effect of any decisions under section 62Q.73, subdivision 7(c). The goal of statutory interpretation is to "ascertain and effectuate the intention of the [L]egislature." Minn. Stat. § 645.16 (2016). "If the Legislature's intent is clear from the statute's plain and unambiguous language, then we interpret the statute according to its plain meaning without resorting to the canons of statutory construction." *State v. Struzyk*, 869 N.W.2d 280, 284–85 (Minn. 2015); *Christianson*, 831 N.W.2d at 537 ("[O]ur role is to enforce the language of the statute and

not explore the spirit or purpose of the law." (citation omitted) (internal quotation marks omitted)).

Under Minnesota's external-review statute, any person covered by a health plan regulated by the Commissioner of Commerce who is denied coverage has a right to "submit a written request for an external review of the adverse determination" to the Commissioner of Commerce. Minn. Stat. § 62Q.73, subd. 3. If a health-plan company denies coverage because it determined that the care was not medically necessary for the insured's condition, the external-review entity may review the insured's condition and the health-plan company's denial to consider whether the denial was "consistent with the definition of medically necessary care in section 62Q.53, subdivision 2." Minn. Stat. §§ 62Q.53, subd. 2, .73, subd. 7(c) (2016). "Medically necessary care" is defined in section 62Q.53, subdivision 2, as:

> [H]ealth care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must: (1) help restore or maintain the enrollee's health; or (2) prevent deterioration of the enrollee's condition.

The external-review decision is "nonbinding on the enrollee and *binding* on the health plan company." Minn. Stat. § 62Q.73, subd. 8 (emphasis added). If a health-plan company disagrees with an external-review decision, it "may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion." *Id.*

Here, Blue Cross does not challenge the external-review decision as arbitrary and capricious or an abuse of discretion, and it does not dispute that it was required to pay for Linn's treatment following the external-review decision. Rather, the parties dispute whether an external-review determination of medical necessity is binding only as to a health plan's obligation to pay an insured's claim, as Blue Cross argues, or whether the determination is also binding as to the definition of medical necessity under a health-plan contract, as the Linns argue.

The Linns claim that the external-review determination on the medical necessity of PBRT treatment proves that Blue Cross breached the Contract when it originally denied coverage. Blue Cross, however, asserts that under the Contract's plain language, it had no contractual obligation to pay for Linn's PBRT, and it fulfilled its statutory obligations when it paid for Linn's PBRT after the external-review decision.[3]

The court of appeals agreed with the Linns, reasoning that the language in section 62Q.73, subdivision 8, making the external-review determination "binding," is plain and unambiguous. *Linn*, 890 N.W.2d at 168 (concluding that "binding means binding"). According to the court of appeals, Blue Cross's definition of medically necessary care in its Contract was constrained by the definition of medically necessary care in section

[3] On appeal, Blue Cross also argued for the first time that Minn. Stat. § 62Q.73, as interpreted by the Linns and the court of appeals, results in an unconstitutional delegation of judicial power in violation of the Minnesota Constitution. We do not reach this constitutional question because Blue Cross did not raise it in the courts below and we decide the case in Blue Cross's favor on other grounds. *See Auto. Merch., Inc. v. Smith*, 212 N.W.2d 678, 679 (Minn. 1973) (stating that we have refused to decide a constitutional issue when it was not litigated in the court below).

62Q.53, subdivision 2. *Linn*, 890 N.W.2d at 168 (stating that the statutory definition of medical necessity has a "broad application" to health-plan contracts "outside of the realm of the external review"). The court of appeals therefore rejected Blue Cross's contention that external-review determinations of medical necessity are "binding only as to payment of the claim submitted, not as to the contract definition of medical necessity." *Id.* To hold otherwise, the court concluded, would effectively "add caveats to the term 'binding,' " and it could not "add words or phrases to an unambiguous statute." *Id.* Even if the statute was ambiguous, the court concluded that its decision was supported by the statute's legislative history and the U.S. Supreme Court's decision in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).[4] *Linn*, 890 N.W.2d at 168–70.

We disagree. We hold that the unambiguous language of section 62Q.73, subdivision 7(c), plainly establishes that an external-review decision is an independent determination of medical necessity, not a legal interpretation of a contract's definition of

[4] The court of appeals determined that *Moran* supports its conclusion, noting that external-review decisions are "authoritative determination[s] of the HMO's medical obligations." *See Linn*, 890 N.W.2d at 169 (citing *Moran*, 536 U.S. at 374). But *Moran* supports the opposite conclusion. 536 U.S. at 383–84 (holding that ERISA did not preempt the Illinois external-review statute because the external-review process did not conflict with ERISA's enforcement scheme). The *Moran* Court emphasized that "the reference to an independent reviewer is similar to the submission to a second physician," akin to a second "medical opinion." *Id.* at 383 (reasoning that the external review did not "*resemble either contract interpretation* or evidentiary litigation before a neutral arbiter" (emphasis added)). The Court therefore held that Illinois's external-review statute was not preempted by ERISA because the external-review process was a part of an internal-appeals process that did not provide a new claim for relief. *Id.* at 379–80. Rather, the external-review process merely prohibited an insurer's "unfettered discretion" in interpreting medical necessity through only contractual terms. *Id.* at 386.

medical necessity.

Section 62Q.73, subdivision 7(c), limits the effect of external-review decisions for health-plan companies that are licensed under chapters other than chapter 62D, such as Blue Cross, which is licensed under chapter 62C.[5] Specifically, subdivision 7(c) expressly limits the external review to determining only "whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2." In other words, the Legislature only delegated authority to external-review entities to determine, in their independent opinion, whether a denied treatment was medically necessary for the insured under the *statutory* definition of "medically necessary care" in section 62Q.53, subdivision 2. To the extent that the Legislature enabled an external-review entity to interpret law, therefore, an external-review entity can only interpret the *statute* defining medical necessity, not a health-plan contract's definition of medical necessity.

In fact, the plain language of section 62Q.53 establishes that the definition of "medically necessary care" in section 62Q.53, subdivision 2 does not displace the definition of "medically necessary care" in health-plan contracts, except for mental-health services. As specified in section 62Q.53, subdivision 1 (2016), the subdivision 2 definition only prevents an insurer from using a "more restrictive" definition of medically necessary care than the statutory definition for "mental health services." Section 62Q.53 therefore does not prohibit health-plan companies from using a more restrictive definition of medical

[5] Chapter 62D governs Health Maintenance Organizations (HMOs).

necessity in contract provisions that do not provide mental-health coverage.

Indeed, apart from section 62Q.53, subdivision 1, only section 62Q.73, subdivision 7(c)—containing the standard of review for external-review determinations of medical necessity—references the definition in section 62Q.53, subdivision 2. No other section in Chapters 62C or 62Q requires a health plan to apply the definition in section 62Q.53, subdivision 2, to a health-plan contract. The Legislature could have required health plans to use the definition in section 62Q.53, subdivision 2 throughout Chapter 62, but it did not do so.

We "do not, and cannot, add to a statute words intentionally or inadvertently omitted by the Legislature." *J.D. Donovan, Inc. v. Minn. Dep't of Transp.*, 878 N.W.2d 1, 13 (Minn. 2016). The Contract's PBRT medical policy, which determined medical necessity of PBRT for insureds, is not related to mental-health coverage, so the statutory definition of medical necessity for PBRT did not supersede the Contract's definition of medical necessity. Blue Cross was free to adopt a more restrictive definition of medical necessity for PBRT than the statutory definition of medical necessity in section 62Q.53, subdivision 2.

Because (1) the external-review entity had authority only to interpret the statutory definition of medical necessity, and (2) the statutory definition of medical necessity did not displace the contractual definition of medical necessity in this case, we conclude that the external-review decision by MAXIMUS did not establish a legally binding interpretation of medically necessary PBRT under the Contract. In other words, the external-review

decision created only a statutory obligation, not a contractual obligation, for Blue Cross to pay Linn's claim for PBRT.

Concluding otherwise would expand the effect of external-review decisions beyond what the Legislature intended under section 62Q.73, subdivision 7(c). Blue Cross's medical policies are part of a managed-care system that reduces utilization costs through medical-necessity determinations and utilization reviews. Blue Cross, through its health-plan Contract, defined what it considered to be medically necessary PBRT for its insureds. The external-review process under section 62Q.73, subdivision 7(c), provided an independent, external check on Blue Cross's interpretation of medically necessary PBRT. *Cf. Moran*, 536 U.S. at 383–84, 386 (concluding that Illinois' external-review statute, which is similar to Minnesota's statute, prohibited an insurer's "unfettered discretion" in interpreting medical necessity through contractual terms). In other words, the external-review process worked as intended.

The language of section 62Q.73, subdivision 7(c) is plain and unambiguous, so our analysis ends there. Minn. Stat. § 645.16 ("When the words of a law in their application to an existing situation are clear and free from all ambiguity, the letter of the law shall not be disregarded under the pretext of pursuing the spirit."); *Christianson*, 831 N.W.2d at 537 ("If the meaning [of a statute] is plain, then our inquiry ends."). Accordingly, we reverse the court of appeals' holding that a determination of medical necessity by an external-review entity under section 62Q.73, subdivision 7(c), is contractually binding on a health-plan company.

II.

Second, we consider whether the district court properly concluded that Blue Cross was entitled to summary judgment based on the Contract's definition of medically necessary PBRT. Once it concluded that the Contract's definition of medically necessary PBRT had been superseded by the statutory definition, the court of appeals held that the district court erred by granting summary judgment to Blue Cross. 890 N.W.2d at 172.

The construction of a contract, such as the health-plan contract here, is a question of law, so we review the district court's interpretation of the contract's language de novo. *See Bus. Bank*, 769 N.W.2d at 288. When interpreting a health-plan contract, as with any contract, "the plain and ordinary meaning of the contract language controls, unless the language is ambiguous." *Id.*; *see also Remodeling Dimensions, Inc. v. Integrity Mut. Ins. Co.*, 819 N.W.2d 602, 611 (Minn. 2012) ("Insurance policies are contracts and, absent statutory provisions to the contrary, general principles of contract law apply.").

Here, the Contract provided that "[a]ll services must be medically necessary to be covered, and even though certain noncovered services may be medically necessary, there is no coverage for them." The PBRT medical policy, incorporated into the Contract by reference, established that PBRT "may be medically necessary" for:

> Postoperative therapy (with or without conventional high-energy x-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine and have residual localized tumor without evidence of metastasis[.]

The policy further provided that "[a]ll other applications of [PBRT] are considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health

outcomes." The Contract did not provide coverage for care that was "investigative" or "not medically necessary."

The parties presented two different interpretations of the PBRT policy before the district court. The Linns argued that the policy language covered Linn's condition because he underwent a biopsy, he had a residual localized tumor without evidence of metastasis, and the PBRT was postoperative therapy following his two prior surgeries. Blue Cross, however, argued that the Contract defined medically necessary PBRT based on the type and location of a tumor, and the Linns' interpretation of the Contract was not consistent with the plain language of the PBRT policy. Specifically, Blue Cross asserted that the Contract excluded coverage for Linn because PBRT was only medically necessary to treat chondrosarcoma of the "basisphenoid region" or the "cervical spine," and it is undisputed that Linn's chondrosarcoma was instead in his thoracic spine.

We conclude that the district court properly granted summary judgment to Blue Cross because the Contract unambiguously excluded coverage of PBRT for chondrosarcoma in the thoracic spine. *See Storms, Inc. v. Mathy Constr. Co.*, 883 N.W.2d 772, 776 (Minn. 2016) (stating that, when a contractual provision is unambiguous, we must not "rewrite, modify, or limit its effect by a strained construction"). Because the Contract's PBRT medical policy emphasized the tumor type and location in every section of the policy defining when PBRT was medically necessary, we agree with Blue Cross. *See Art Goebel, Inc. v. N. Suburban Agencies, Inc.*, 567 N.W.2d 511, 515 (Minn. 1997) ("[Ambiguity] depends, not upon words or phrases read in isolation, but rather upon the meaning assigned to the words or phrases in accordance with the apparent purpose of the contract as a

whole."). Accordingly, we hold that the Contract plainly excluded PBRT for Linn's condition, and Blue Cross did not have a contractual obligation to pay Linn's claim for PBRT. We need not consider whether Blue Cross breached its promise to provide "timely" services given that it had no contractual obligation to pay for the care here.

We therefore reverse the court of appeals' decision and reinstate the district court's grant of summary judgment to Blue Cross. Although Blue Cross had a statutory obligation to pay the claim after the external-review decision, it did not have a contractual obligation to pay the claim.

CONCLUSION

For the foregoing reasons, we reverse the decision of the court of appeals.

Reversed.

LILLEHAUG, J., took no part in the consideration or decision of this case.

CHUTICH, J., took no part in the consideration or decision of this case.