

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. 151410-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 15th day of January 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage for physical therapy visits by her health insurer carrier, Blue Cross Blue Shield of Michigan (BCBSM).

On December 21, 2015, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on December 30, 2015.

The Petitioner receives health care benefits through a group plan underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on January 8, 2016.

The issue in this external review can be decided by a contractual analysis. 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 health care benefits are defined in BCBSM's *Community Blue Group Benefits Certificate SG* (the certificate).¹

On February 14, 2015, the Petitioner injured her knee while skiing and required surgery to repair the damage. On February 23, 2015, she began outpatient physical therapy that continued through September 21, 2015. BCBSM covered 30 visits between February 23 and July 31, 2015, but denied coverage for further visits because they exceeded the calendar year visit maximum.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated December 2, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is BCBSM required to provide cover physical therapy beyond 30 visits?

IV. ANALYSIS

Petitioner's Argument

In a letter of appeal to BCBSM dated November 2, 2015, the Petitioner wrote:

On February 14, 2015, I injured my knee skiing. I made phone calls that following week to Blue Cross Blue Shield to see what was going to be covered and what I was going to be responsible for going forward to have my knee surgery and therapy. At this time I was told of my deductibles and co-insurance amounts. I was informed that my physical therapy would be covered up to 30 visits. I moved forward with my surgery, and began my physical therapy per my doctor's advisement and recommendations. At this time, I called Blue Cross again, as I had met all my deductibles and co-insurances so I should have no more out of pocket expenses, so I was calling to verify that this was in fact the case. I asked several representatives about my coverage for physical therapy and was informed that because I had met all my deductibles and co-insurances, I would have no more out of pocket expenses for the remainder of my year. I was not told again of the 30 limit visit for physical therapy, so I figured this was irrelevant due to the fact I met all my deductibles and co-insurances. I continued my physical therapy per my doctor's orders under the impression from my phone calls with Blue Cross Blue Shield that it was all being covered 100%.

¹ BCBSM form No. 898, effective 08/2015.

I received a bill from my physical therapy office on September 20, 2015. Upon calling their billing office, they informed me that Blue Cross Blue Shield had denied paying for these services. I contacted Blue Cross Blue Shield on September 24, 2015 and they informed me the claim had been denied but they would look into the reason why as I had reached all my deductibles and co-insurances. I was to receive a call back within 7-10 business days. At this time I immediately ceased my visits to physical therapy, even though my doctor and physical therapist still wanted to treat me, until this matter was resolved.

After not hearing back on this matter, I called again on October 14, 2015 and spoke with yet another agent. She informed me then that the bill was denied because I had went over my 30 limit visit. She was going to look into the matter and call me back within 7-10 business days. I was contacted on Friday, October 30, 2015 from a Blue Cross Blue Shield representative, and was informed that after reviewing my matter, the claim is still denied and I must pay for these services. At this time they gave me the Appeals Unit information, and I was told I could send a letter with my matter in writing to dispute and hopefully have these physical therapy charges paid for by Blue Cross Blue Shield.

In conclusion, I would like to let you know I am a single parent of two small children on a fixed income. I do not have extra set aside for these therapy bills, as I was trying to plan since the accident occurred in February by placing the proper phone calls and making sure I knew all of my out of pocket expenses. My accident was unfortunate, and I am an extremely active person and this injury has made it very difficult for me to do many things. The physical therapy I was doing was helping my healing process and I was by all means not trying to take advantage of anything, just trying to do what I could to get my knee back to "normal." I hope that you can take this all into advisement when you make your decision on this matter and covering my physical therapy.

BCBSM's Argument

In its final adverse determination, BCBSM's representative explained to the Petitioner:

After review of the claims for physical therapy services you received on August 4, 13, 21, and 28, 2015 and September 8, 14, and 21, 2015, I confirmed that the denial of payment is appropriate because you already met the maximum thirty (30) outpatient physical therapy services for the 2015 calendar year. As a result, no payment is available.

* * *

I completed a detailed review of the claims reported to BCBSM for physical therapy services you received in 2015. According to our records, you received physical therapy services (prior to August 4, 2015) on the following dates:

- February 23, and 26, 2015,
- March 6, 9, 11, 13, 16, 18, 20, 24, 27, and 30, 2015,
- April 1, 6, 13, 16, 20, and 23, 2015,
- May 1, 7, 14, 22, and 29, 2015,
- June 4, 11, and 29, 2015, and
- July 6, 13, 23, and 31, 2015,

As a Grievance and Appeals Coordinator, it is my responsibility to ensure that the claims at issue processed according to plan design. As explained above, because you exhausted the benefit maximum for physical therapy services for the 2015 calendar year, payment is not available for physical therapy services you received on or after August 4, 2015.

Director's Review

The certificate (p. 72) describes the physical therapy benefit:

We pay for:

- Medically necessary physical therapy services subject to the following:

* * *

- A maximum of 30 outpatient visits per member per year.

Important: See Note below about treatment dates and initial evaluations. This 30 visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:

- **Occupational therapy**
- **Physical therapy (includes physical therapy by a chiropractor)**
- **All chiropractic manipulations**
- **Osteopathic manipulative therapy**

The Petitioner acknowledged that BCBSM told her that she had a 30-visit maximum for physical therapy when she initially called. For some reason the Petitioner thought that her physical therapy benefit would renew once she had met her deductible and other cost sharing maximums. But she was not told that by BCBSM and the certificate clearly says that the 30 visit maximum "renews each calendar year."

BCBSM covered 30 visits for physical therapy as it was obligated to do under the terms of the certificate. While it is unfortunate the Petitioner required more than 30 visits to treat her condition, nothing in the certificate or Michigan law requires BCBSM to cover more than 30 therapy sessions, even if additional visits are medically necessary.

The Director concludes that BCBSM was correctly denied coverage for the physical therapy visits after July 31, 2015, under the terms and conditions of the certificate.

V. ORDER

The Director upholds Blue Cross Blue Shield of Michigan's final adverse determination of December 2, 2015.

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 60 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, P.O. Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director



Randall S. Gregg
Special Deputy Director