

STATE OF MICHIGAN  
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES  
Before the Director of Insurance and Financial Services

In the matter of:

██████████  
Petitioner

v

University of Michigan, Plan Sponsor  
and  
Blue Cross Blue Shield of Michigan, Plan Administrator  
Respondents

File No. 145405-001-SF

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Issued and entered  
this 7<sup>th</sup> day of January 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On December 15, 2014, ██████████, authorized representative of her adult daughter ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* The Petitioner is challenging a health care claim denial by Blue Cross Blue Shield of Michigan (BCBSM). On December 22, 2014 after a preliminary review of the material submitted, the Director accepted.

The Petitioner receives health care benefits through a self-funded group plan sponsored by the University of Michigan. BCBSM administers the plan. Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

The Petitioner's health care benefits are defined in BCBSM's *Community Blue Group Benefits Certificate*. The Director notified BCBSM of the request for review and asked for the information it used to make its final adverse determination. BCBSM provided its response on January 2, 2015.

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 suffers from depression. Her treatment involved 31 sessions of transcranial magnetic stimulation (TMS) therapy conducted between September 7 and November 30, 2013.

BCBSM denied coverage for the first treatment (provided on September 7, 2013) and the Petitioner appealed that denial through both BCBSM's internal grievance process and the Department of Insurance and Financial Services external review process. BCBSM cited two reasons for its initial coverage denial: the absence of a prior authorization request by the Petitioner and BCBSM's belief that the TMS therapy was prescribed to treat anxiety rather than depression. The Director found these reasons to be invalid as reasons to deny coverage. The Director found that prior authorization was not required for outpatient mental health treatment according to the terms of the *Community Blue Group Benefits Certificate*. The Director also found that the treatment was, in fact, for of the Petitioner's depression.

Based on these findings, on March 5, 2014, the Director issued an order requiring BCBSM to cover the Petitioner's September 7, 2013 treatment. See Department of Insurance and Financial Services Order, File No. 138936.

In October 2014, the Petitioner appealed BCBSM's denial of the remainder of her TMS care (provided between September 9, 2013 and November 30, 2013) through BCBSM's internal grievance process. On November 19, 2014, BCBSM affirmed its coverage denial. In the final adverse determination issued to the Petitioner's mother, BCBSM wrote:

A review of your daughter's claims indicate that the provider...reported procedure code 90867 (therapeutic repetitive Trans cranial magnetic stimulation treatment; initial, including cortical mapping, motor threshold determination, delivery and management) and 90868 (therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management, per session) to identify your daughter's outpatient mental health services. According to the Blue Cross Blue Shield of Michigan *Medical Affairs Policy Change Clarification*, repetitive transcranial magnetic stimulation services (identified by procedure codes 90867, 90868, 90869) are only a benefit to members that meet medical necessity criteria, have outpatient mental health benefits, and belong to an underwritten group or a self-funded group that provides the benefits.

The [REDACTED] that provides your family with health care coverage is a self-funded group and does not provide benefits for transcranial magnetic stimulation treatment.

During our conversation on November 14, 2014, you indicated that payment should be approved for your daughter's services because the Department of Insurance and Financial Services reviewed her [September 7, 2013 treatment] and approved it for payment. However, the Department of Insurance and Financial Services determination only applies to your daughter's [September 7, 2013 treatment], and does not reflect the dates of service that are being reviewed during this internal appeal. Thus, our denial of payment is maintained and your daughter is liable for the amount in question reference above.

The Petitioner now seeks a review of BCBSM's adverse determination from the Director.

### III. ISSUE

Is BCBSM required to provide coverage for the Petitioner's TMS treatments received between September 9 and November 30, 2013?

### IV. ANALYSIS

In the present case, BCBSM has relied on a different reason for denying coverage than the reasons cited in the Petitioner's first appeal. The reason now relied upon by BCBSM is the fact that TMS therapy is not a covered benefit, regardless of whether prior authorization was requested and regardless of whether the treatment was prescribed for anxiety, depression, or any other condition.

In support of its decision, BCBSM has submitted a copy of its *Medical Affairs Policy Change Clarification* which indicates that TMS therapy is not a covered benefit for self-funded groups. It is not clear why BCBSM failed to cite this reason in the earlier case, since the *Medical Affairs Policy Change Clarification* was in effect at the time of the first appeal. Nevertheless, the reason cited by BCBSM for denying coverage in the present appeal is a correct application of the terms of the Petitioner's health benefit plan.

The Director finds that the Petitioner's TMS therapy is not a covered benefit.

### V. ORDER

BCBSM's final adverse determination of November 19, 2014, is upheld.

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 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.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director