

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. 148680-001-SF

University of Michigan, Plan Sponsor

and

Blue Cross Blue Shield of Michigan, Plan Administrator

Respondents

Issued and entered
this 25th day of July 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 6, 2015, ██████████ (Petitioner) filed a request for external review with the Department of Insurance and Financial Services. The request for review was filed under Public Act No. 495 of 2006, (Act 495) MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952).

The Petitioner's primary health care coverage is provided through Medicare. Additional benefits are provided through a governmental self-funded plan sponsored by the University of Michigan and administered by Blue Cross and Blue Shield of Michigan (BCBSM). The plan's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC*.

On July 13, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on July 21, 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

Between January 7 and February 27, 2015, the Petitioner received physical therapy services from [REDACTED] Physical Therapy. Medicare provided coverage for a portion of the expense. BCBSM approved secondary coverage and applied copayments totaling \$313.20.

The Petitioner appealed the copayment charges through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination on June 17, 2015, affirming its position. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly require the Petitioner to pay \$313.20 in copayment charges for her physical therapy?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination to the Petitioner, BCBSM wrote:

You are covered under the *Community Blue Group Benefits Certificate ASC (Certificate)*. Page 71 of **Section 3: What BCBSM Pays For** explains that your health care plan covers a combined benefit maximum of 60 visits per member, per calendar year for physical therapy, occupational therapy, chiropractic spinal manipulations, mechanical traction and osteopathic manipulative therapy.

However, the plan's Benefit Package Report (BPR), which is the online tool used by [BCBSM] to house procedure specific information for your plan, indicates a copayment requirement. According to the BPR, your plan applies a \$25 copayment to the following procedures: procedure code 97001 (Physical therapy evaluation), 97110 (Therapeutic exercises, each 15 minutes), and 97140 (Manual therapy techniques, 1 or more regions, each 15 minutes).

In your appeal letter, you explained that the provider was informed by a BCBSM Customer Service Representative that your physical therapy services would be covered at 100 percent of the BCBSM approved amount. While I regret your provider received incorrect information. As a Grievance and Appeals Coordination for BCBSM, it is my responsibility to ensure the claims at issue processed according to the Plan Design. As a result, I cannot make an exception on your behalf. You remain liable for the copayment amounts totaling \$313.20.

Petitioner's Argument

In a letter attached to her request for external review, the Petitioner wrote:

On January 7, 2015 I started at [REDACTED] Physical Therapy after a staff member from [REDACTED] confirmed with [BCBSM] Customer Service Rep that I had 100% coverage for the upcoming therapy. I had PT in January of 2014 that was covered at 100% at [REDACTED] hospital following my bilateral mastectomy. Because of immense medical expenses in the previous year I was adamant that I needed to know the whole picture financially prior to starting PT. Based on [BCBSM] info given to [REDACTED] I went ahead with the therapy recommended by...one of the therapists.

BCBSM denied my coverage at 100%, back peddled and required me to pay a copay. I appealed their decision on May 14 of this year. They again denied my request.

I am wondering how I can trust my insurance company to tell me they cover something especially big procedures if they don't stand behind the word their employees give over the phone. I believe that [BCBSM] should stand behind their employees whom informed [REDACTED] that my coverage was 100%. It is my understanding that there is a recorded phone call where they admit this is the information their employee passed on incorrectly. I request that you review this case and hold [BCBSM] accountable for their verbal approval of this service.

Services 1/7/15 to 2/27/15, charges disputed \$313.20.

Director's Review

The *Community Blue* certificate (pages 8, 9 and 71) provides coverage for physical therapy. The coverage was 100 percent of BCBSM's approved amount. The certificate was modified effective January 1, 2015 to change the cost sharing requirements for several benefits. The copayment requirement for physical therapy was changed as follows:

This modification ADDS a copayment requirement of \$25 per visit for physical, occupational and speech language pathology services by an in Network professional provider. In Network facility billed physical, occupational and speech therapy language pathology services remain covered at 100% of the approved amount and are not subject to the \$25 copayment requirement.

In conducting reviews under the PRIRA, the Director is limited to resolving question of medical necessity and determining whether an insurer's final adverse determination is consistent with the terms of the relevant policy or certificate of coverage. See MCL 550.1911(13). While it may be true that the Petitioner's provider was given inaccurate information regarding her

benefits, the benefits are as written in the certificate and any related amendments. Under the Patient's Right to Independent Review Act, the Director has no authority to amend the terms of an insurance policy to require BCBSM to provide coverage that is inconsistent with the Petitioner's actual benefits.

V. ORDER

The Director upholds BCBSM's final adverse determination of June 17, 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 sixty 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, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director