STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of Insurance and Financial Services

In the matter of:

[redacted]
Petitioner

v **File No. 152062-001-SF**

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

Issued and entered
this 2nd day of March 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 4, 2016, [redacted] (Petitioner) filed a request for external review with the Department of Insurance and Financial Services. The request for review concerns a denial of coverage issued by Blue Cross Blue Shield of Michigan (BCBSM) for orthotic devices. BCBSM is the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The plan's benefits are described in BCBSM's *State Health Plan PPO Benefit Guide.*

The request for external 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 health benefit plan is such a governmental self-funded plan.

On February 11, 2016, after a preliminary review of the information submitted, the Director accepted the request for review. The Director notified BCBSM of the appeal and asked it to provide the information used to make its final adverse determination. BCBSM furnished its response on February 16, 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

On October 26, 2015, the Petitioner ordered a pair of orthotics (molded removable foot inserts). The amount charged was $375.00. BCBSM denied coverage.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination dated January 8, 2016, upholding its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. Issue

Is BCBSM required to provide coverage for the Petitioner's orthotics?

IV. Analysis

Petitioner's Argument

With his request for an external review, the Petitioner submitted a copy of a December 2, 2015 letter to BCBSM in which he wrote:

> [My doctor] suggested I call your customer support line to verify coverage which I did and was told my policy covers 2 units per year.
>
> I understood that a unit was a pair of orthotics because, I was told, that they are always prescribed in pairs so as to not throw off one's gait. I received the first pair which were covered and they seemed to help.
>
> In late October I ordered what I thought was the second unit but when they arrived six weeks later I was told that BCBS rejected the claim because I had exceeded my quota. After talking with [my doctor's] office and the BCBS customer support line I now understand that a unit is a single shoe, although I do not feel that was completely explained to me on my first call. My problem is I have a second pair and an amount due of $370.
>
> I understand my quota is calendar year based so if I had waited a few months they would have been covered in 2016. I am appealing to you for a one-time exception. Would it be possible to have the second pair count as my 2016 units?

BCBSM's Argument

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

> You purchased two orthotic inserts, procedure code L3020 (foot insert, removable), after you had reached your benefit maximum of two (2) units per calendar year. You remain responsible for the non-covered charges totaling $375.00.
>
> You are covered by the State of Michigan Active Employee State Health Plan PPO. Page 13 of *Your Benefit Guide, State Health Plan PPG,* explains that your Plan covers prosthetic and orthotic services. However, these services are subject to limitations.
>
> According to the *Benefit Package Report,* which is an online tool used by BCBSM to house procedure specific group benefit information, procedure code L3020 is a covered benefit limited to two (2) units per calendar year.
>
> In this case, BCBSM received a claim for the date of service July 1, 2015, for two (2) units of procedure code L3020. In accordance with the terms of your coverage, BCBSM paid its approved amount for the covered services. As a result, procedure code L3020 was not eligible for payment before January 1, 2016. We received a claim for additional orthotic inserts purchased on October 26, 2015, before the services were eligible for payment. Therefore, the orthotic shoe inserts you purchased in October are not covered services under the terms of your coverage, and we must maintain our denial.
>
> In your appeal letter and during your managerial-level conference, you indicated that you spoke with a BCBSM customer service representative to confirm your orthotic benefits. To ensure all consideration was given to you, I accessed your conversations with our BCBSM representatives. After review, I was unable to confirm that you were provided inaccurate or misleading benefit information. As a result, I am unable to honor your request for payment.

Director's Review

The Petitioner's health plan provides coverage for prosthetic and orthotic supplies. However, some limitations to this coverage apply. Specifically, the plan limits the quantity of orthotic supplies a member may receive to two units per calendar year. The Petitioner received a pair of orthotics on July 1, 2015, for which BCBSM provided coverage.

The Petitioner argues that he was given misleading information from BCBSM's representatives that a second pair of orthotics would be covered. BCBSM asserts that the Petitioner was not given misleading information, but may have misunderstood the term "units" to mean "pair." Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether an insurer or plan administrator has properly applied the terms of the applicable insurance contract and any relevant Michigan statute.

In this case, the plan covers two orthotic units (one pair) per calendar year. The Respondents provided coverage for the first two orthotics which were obtained in July 2015.

The Director concludes that BCBSM denial of coverage for two additional units was consistent with the limitations imposed by the plan.

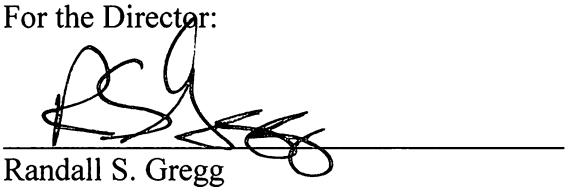
V. ORDER

The Director upholds BCBSM's final adverse determination of January 8, 2016. The Respondents are not required to provide coverage for the orthotics the Petitioner obtained in October 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 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