

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. 152724-001

Blue Cross Blue Shield of Michigan
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On March 17, 2016, ██████████, authorized representative of her ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on March 24, 2016.

The Petitioner receives health care coverage through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs LG*. The Director notified BCBSM of the request and asked for the information used to make its final adverse determination. BCBSM provided its response on April 1, 2016.

The issue in this external review can be decided by a contractual review. 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

In the fall of 2015, the Petitioner was treated for anorexia nervosa at ██████████ ██████████ in Lemont, Illinois. On September 11, September 29, October 2, and October 9, 2015, the Petitioner was seen at ██████████ by physicians from Adventist Health Partners. Claims were submitted to BCBSM for these services. In its claims, Adventist Health Partners identified the September 11 visit as "Domiciliary or rest home visit for the evaluation

and management of a new patient.” The other visits were identified as, “Domiciliary or rest home visit for the evaluation and management of an established patient.”¹ Adventist Health Partners, a physician group, does not participate with BCBSM or the Illinois Blue Cross Blue Shield plan. The total amount charged for these services was \$1,263.00. BCBSM denied coverage.²

The Petitioner appealed the denial through BCBSM’s internal grievance process. At the conclusion of that process, BCBSM affirmed its denial and issued a final adverse determination on February 16, 2016. The Petitioner now seeks the Director’s review of that determination.

III. ISSUE

Did BCBSM correctly deny coverage for the services provided to the Petitioner by Adventist Health Partners?

IV. ANALYSIS

Respondent’s Argument

In the final adverse determination to Petitioner’s mother, BCBSM’s representative wrote:

After review, I confirmed the denial of payment is correct because the following services are not a benefit of the plan:

- Domiciliary or rest home visit, new patient (procedure code: 99328),
- Domiciliary or rest home visit, established patient (procedure code: 99336) (x2), and
- Domiciliary or rest home visit, established patient (procedure code: 99335).

As a result, the cost of the services listed above totaling \$1,263.00 remains [the Petitioner’s] responsibility.

[Petitioner] is covered under the *Simply Blue HSA Group Benefits Certificate with Prescription Drugs LG* (Certificate). According to section titled "Mental Health Services" on Page 56 of the Certificate, we do not pay for services provided through a residential substance abuse treatment program.

According to the information submitted by Adventist Health Partners, Inc., the services were provided in a residential substance abuse facility. Specifically, as explained in the Benefit Package Report (BCBSM's online reference tool for procedure code specific benefit information) for your group; procedure codes

1. These descriptions are associated with CPT codes 99328, 99335, and 99336. CPT codes are a numerical coding system compiled by the American Medical Association and published in its manual, *Current Procedural Terminology*. The codes in this manual, usually five digit numbers, are used by providers and others to describe medical services when claims are submitted to insurers.

2. It appears that the Petitioner’s treatment provided by [REDACTED] was approved by BCBSM. Based on the material submitted for this review, BCBSM only denied claims from Adventist Health Partners.

99328, 99336, and 99335 are not covered benefits of the plan. As a result, no payment is available.

Lastly, during the managerial-level conference, you stated that the rest home or custodial care services were previously paid by BCBSM. I completed a detailed review of the claims reported to BCBSM. According to our records, no other claims were submitted to BCBSM for procedure codes 99328, 99336, and 99335. As a Grievance and Appeals Coordinator, it is my responsibility to ensure that the claims at issue processed according to plan design. As a result, because the services reported are not benefits of [Petitioner's] plan, an exception cannot be granted on behalf of [Petitioner]. She remains liable for the non-covered services.

Petitioner's Argument

In a letter dated March 14, 2016 accompanying her request for an external review, Petitioner's mother wrote:

I want to point out that [REDACTED] isn't just a facility for substance abuse, therefore the total disregard for what [Petitioner] was being treated for and approved to be treated for has been totally overlooked....

My [REDACTED] has been diagnosed with Anorexia Nervosa since May 26, 2014 and her diagnosis has not changed. The one error my insurance company continues to make is their approval to cover Anorexia which is why her treatment was cut short and the reason she is still in treatment because the Nervosa part was being denied.

The true definition of **Anorexia Nervosa**; a serious disorder in eating behavior primarily of young women in their teens and early twenties that is characterized especially by a pathological fear of weight gain leading to faulty eating patterns, malnutrition and usually excessive weight loss.

The true definition of **Anorexia**; loss of appetite and inability to eat.

My [REDACTED] has suffered tremendously because she was released from treatment before she was 85% weight restored. The practitioners couldn't even begin to work with the psychological aspect of this disorder until she was at least 80% because of the lack of ability to concentrate and retain information from malnourishment. The insurance company refused to continue approval for her stay under the diagnosis of **Anorexia Nervosa**. Although I'm appealing [BCBSM's] decision I'm appealing the mislabeling of my [REDACTED] condition and the seriousness of this ongoing disorder.

Director's Review

The Petitioner's representative is correct in asserting that BCBSM has erroneously described [REDACTED] as a substance abuse treatment facility. According to its web site, [REDACTED] provides residential treatment for eating disorders, depression, drug and alcohol addiction, trauma and PTSD, and mood and anxiety disorders. The Petitioner was treated there for anorexia nervosa, an eating disorder. BCBSM is also in error when it states in the final adverse determination that "we do not pay for services provided through a residential

substance abuse treatment program.” In fact, residential substance abuse treatment is a benefit under the Petitioner’s plan and is described on page 102 of the *Simply Blue HSA Group Benefits Certificate*. However, the issue to be resolved in this review is whether the specific services provided by Adventist Health Partners are covered benefits under the Petitioner’s benefit plan.

Adventist Health Partners billed BCBSM for procedure codes 99328, 99336, and 99335 which is care provided in a domicile or rest home. These CPT codes, according to the American Medical Association’s *Current Procedural Terminology* manual (see footnote #1, above), are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis....The facility’s services do not include a medical component.” [REDACTED] is not such a facility.

The *Simply Blue HSA Group Benefits Certificate* provides coverage for mental health services including residential psychiatric treatment which is described on page 53:

Residential psychiatric treatment is covered only after it has been preauthorized by BCBSM or its representative. Covered services must be provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

We pay for:

- Services provided by facility staff
- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Prescribed drugs given by the facility in connection with the member’s treatment plan

The Adventist Health Partners services were not “services provided by facility staff.” In addition, [REDACTED] is not a domicile or rest home. For that reason, the claims submitted by Advent Health Partners do not correctly describe the type of service provided. For these reasons, the Director agrees with BCBSM that the Adventist Health Partners services are not covered benefits.

The Director finds that BCBSM’s denial of procedure codes 99328, 99336, and 99335 provided by the Adventist Health Partners on September 11, 2015, September 29, 2015, October 2, 2015 and October 9, 2015 is consistent the terms of the *Simply Blue HSA Group Benefits Certificate*. Because Adventist Health Partners’ physicians are not Timberline Knolls facility staff and because Adventist Health Partners identifies its claims as services provided in a domicile or rest home, the claims do not fall within the benefit plan’s coverage.

V. ORDER

The Director upholds BCBSM's February 16, 2016 final adverse determination. BCBSM is not required to provide cover for the services provided to the Petitioner on September 11, 2015; September 29, 2015; October 2, 2015; and October 9, 2015 by Adventist Health Partners.

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, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:

A handwritten signature in black ink, appearing to read 'RSG', is written over a horizontal line.

Randall S. Gregg
Special Deputy Director