

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. 153895-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of June 2016
by **Randall S. Gregg**
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 26, 2016, ██████████ (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 information submitted, the Director accepted the case for review on June 3, 2016.

The Petitioner receives health care benefits through a plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Blue Cross Premier Silver Certificate*.

The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. BCBSM provided its response on June 6, 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 received physical therapy and occupational therapy in October, November, and December 2015. BCBSM denied coverage for the therapy the Petitioner received after

October 21, 2015, the date, according to BCBSM, that the Petitioner had exhausted his maximum therapy benefit for the year. The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, on March 30, 2016, BCBSM issued a final adverse determination affirming its denial. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Is BCBSM required to pay for the Petitioner's physical and occupational therapy received after October 21, 2015?

IV. ANALYSIS

BCBSM's Position

In its final adverse determination, BCBSM stated:

After review, I must maintain denial of payment for physical and occupational therapy services from October 26, 2015, through December 30, 2015. Under your coverage, BCBSM pays for a maximum of 30 combined outpatient visits for physical therapy, occupational therapy, chiropractic manipulations and osteopathic manipulative therapy. We have already paid the maximum number of physical and occupational therapy visits under your plan.

* * *

On October 21, 2015, [Petitioner] reached the maximum visits allowed under the contract, and any occupational therapy, physical therapy, chiropractic manipulations, and osteopathic manipulative therapy services rendered after this date are not covered until the following calendar year.

I understand your concern that you received general information regarding these visits from [the Petitioner's] case manager, and that is why you scheduled the physical therapy visits. However, while your contract allows for 30 total visits for physical and occupational therapy, all specific benefit information, including remaining visits, should be verified with a customer service representative. I confirmed we have no record of any telephone calls prior to the dates of service in question with regard to benefits for physical therapy. We must process claims according to the terms and limitations of your health care coverage. As a result, I am unable to make an exception on your behalf, and you remain liable for the non-covered charges.

Petitioner's Position

In the external review request, the Petitioner's wife wrote:

We are requesting an external review of the recent denial of our appeal in regards to outpatient PT and OT visits maximum exceeded. Both [Petitioner] and his physical therapy provider were given the incorrect number of visits of outpatient

therapy visits available to use for [Petitioner's] severe injury on 6/13/15. Our BCBS case manager and BCBS provider verification told us 30 visits. He therefore was scheduled according to that info. When the E.O.B. stated he exceeded maximum days, we called BCBS and asked why it happened. They said we only had 4 days to use for 2015 and to appeal it. We are hoping for the above claims to be paid.

Director's Review

The Petitioner is covered under the *Blue Cross Premier Silver Benefits Certificate*. In **Section 3: What BCBSM Pays For** (page 69) the certificate states:

We pay for:

* * *

- A maximum of 30 outpatient per member per year ... This 30 visit maximum renews each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location, for:
 - Occupational therapy
 - Physical therapy (including physical therapy by a chiropractor)
 - All chiropractic manipulations
 - Osteopathic manipulative therapy

Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

Page 71 of the certificate further states:

- We do not pay for:
 - More than 30 outpatient visits per member per calendar year ... whether obtained from an in-network or out-of-network provider.

BCBSM established that it provided coverage for 30 outpatient therapy visits in the 2015 calendar year. Therefore, any additional physical or occupational therapy provided beyond this date, exceeded the 30-visit maximum allowed under the terms of the certificate for the calendar year, and are not covered benefits. Although the Petitioner may have required more than 30 therapy visits to treat his medical problems, nothing in the certificate or applicable law requires BCBSM to cover more than 30 therapy visits, per member, per calendar year.

The Petitioner argues that BCBSM provided him with inaccurate information about how many therapy visits he had remaining after he had received explanation of benefits forms from BCBSM which indicated he had exceeded the certificate's benefit maximum. BCBSM indicated it found no evidence of such a call with the Petitioner. In conducting reviews under the Patient's Right to Independent Review Act (PRIRA), the Director is limited to resolving questions of medical necessity and determining whether an insurer's final adverse determination is consistent

with the terms of the relevant certificate of coverage. See MCL 550.1911(13). The PRIRA external review system has no hearing process which can resolve factual disputes such as the one described above.

The *Blue Cross Premier Silver Benefits Certificate*, establishes that coverage is limited to a maximum of 30 combined visits of outpatient therapy (physical, occupational, chiropractic spinal manipulations or mechanical traction, and osteopathic manipulative therapy) per member, per calendar year. The Petitioner had reached that maximum by October 21, 2015. No further therapy coverage was available. The Director finds that BCBSM's denial of coverage for the physical and occupational therapy provided between October 22, 2015 and December 31, 2015, was consistent with the terms of the *Blue Cross Premier Silver Benefits Certificate*.

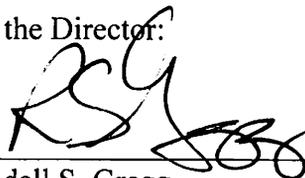
V. ORDER

The Director upholds BCBSM's final adverse determination of March 30, 2016. BCBSM is not required to provide any additional coverage for the Petitioner's 2015 physical and occupational therapy.

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

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director