

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 101348-001

v

Blue Cross and Blue Shield of Michigan
Respondent

Issued and entered
this 27th day of February 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 10, 2008, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on November 18, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on December 1, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Flexible Blue Group Benefits Certificate (the certificate), the contract that defines the Petitioner's health care benefits. The Commissioner 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

From November 14, 2006, through February 27, 2007, the Petitioner received speech therapy services at the XXXXX, a freestanding outpatient physical therapy facility. XXXXX does not participate with BCBSM.

The services were billed under CPT code 92507 ("Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual"). The charge for this therapy was \$1,105.00.

When BCBSM denied coverage for this care, the Petitioner appealed through BCBSM's internal grievance process. BCBSM held a managerial-level conference on January 9, 2008, and issued a final adverse determination dated October 22, 2008.

III ISSUE

Did BCBSM correctly deny the Petitioner's claims for speech therapy at XXXXX?

IV ANALYSIS

Petitioner's Argument

The Petitioner was diagnosed with expressive apraxia of speech which her mother says is a neurological speech disorder that affects a child's ability to plan, execute and sequence the precise series of movements of the tongue, lips, jaw and palate that are required for intelligible speech. It is a motor planning issue that impairs the child's ability to formulate consonants and vowels into spoken words.

The Petitioner's mother believes the speech therapy was necessary to develop the Petitioner's communication skills and that she meets the criteria in the certificate. She cites these criteria in Section 3 of the certificate (page 3.28):

Speech and language pathology services must be:

-- Prescribed by a doctor of medicine, osteopathy or a dentist

- Given for a condition a that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
 - A doctor of medicine or osteopathy
 - A speech-language pathologist certified by the American-Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervisor of a certified speech-language pathologist.

The Petitioner's mother says her daughter meets all these criteria: the Petitioner's pediatrician wrote a prescription; the Petitioner's condition improved in a reasonable time; and the therapy was received from a certified speech-language pathologist.

BCBSM denied coverage for the Petitioner's care at XXXXX because the facility does not participate with BCBSM and because the claims were not billed by a physician. The Petitioner's mother points out that when other medical services are provided by a nonparticipating provider, she pays the cost upfront and submits the claims and BCBSM reimburses her at a lower level than if services were received from a participating provider. She does not understand why the services at XXXXX were denied, saying it "is nothing more than a self-created administrative hurdle designed to prevent subscribers from the coverage they are entitled to." The Petitioner's mother does not understand why XXXXX cannot be a participating provider.

The Petitioner asserts that her care at XXXXX is medically necessary and a covered benefit under her certificate and believes that BCBSM is required to cover it.

BCBSM's Argument

In its final adverse determination BCBSM said:

[The certificate] does not include benefits for services provided at a nonparticipating freestanding facility. * * *

The certificate does not provide for direct reimbursement to speech therapists; services performed in the office setting must be filed by the physician who employs the certified speech-language pathologist and/or registered occupational therapist.

[The Petitioner's] services were not billed by a physician, and the XXXXX is not a participating facility; therefore payment is not available under...your coverage.

BCBSM cites this provision on page 3.30 of the certificate under "Coverage for Hospital, Facility and Alternative to Hospital Care":

We pay for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility. [Emphasis in original]

Since the Petitioner's services were billed and rendered by XXXXX, a nonparticipating free-standing physical therapy facility, BCBSM says it correctly denied coverage for the Petitioner's therapy based on the language of Section 3.

Commissioner's Review

The certificate sets forth how benefits are paid. The certificate makes a distinction between speech therapy provided in a freestanding outpatient physical therapy facility (Section 3) and speech therapy provided in physician or other professional provider's office (Section 4).

In Section 3 of the certificate, "Coverage for Hospital, Facility and Alternatives to Hospital Care," it says (quoted above) that services provided and billed by a freestanding outpatient physical therapy facility will only be covered when that facility participates with BCBSM.

Section 4 of the certificate, "Coverage for Physician and Other Professional Provider Services," also describes coverage criteria for speech therapy (page 4.16):

Speech and language pathology services must be:

- Prescribed by a physician licensed to prescribe them
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

The Petitioner seems to meet these coverage criteria. However, this section deals with speech therapy that is provided in an office setting and billed directly by a physician or other professional provider. Section 4 of the certificate does not apply when the therapy is provided by and billed by a nonparticipating freestanding outpatient physical therapy facility like XXXXX. Because XXXXX does not participate with BCBSM, the speech therapy rendered there is not a covered benefit even if it is medically necessary, prescribed by a physician, and the therapist is appropriately licensed.

Finally, the Commissioner has no authority under the Patient's Right to Independent Review Act to address the issues raised by the Petitioner about XXXXX's participation status with BCBSM.

The Commissioner concludes and finds that BCBSM has denied the Petitioner's claims correctly according to the terms and conditions of the certificate and is not required to cover the Petitioner's speech therapy at XXXXX.

**V
ORDER**

BCBSM's final adverse determination of October 22, 2008, is upheld. BCBSM is not required to cover the Petitioner's care at XXXXX.

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 Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.