

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. 110072-001

v

Physicians Health Plan of Mid-Michigan HMO
Respondent

**Issued and entered
this 7th day of March 2011
by Ken Ross
Commissioner**

ORDER

**I
BACKGROUND**

On October 27, 2010, 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 Petitioner is a member of Physicians Health Plan of Mid-Michigan (PHP). His health care benefits are defined in the *Select Plus HMO* certificate of coverage issued by PHP.

On November 1, 2010, PHP provided OFIR with the information used in making its final adverse determination. On November 3, 2010, after a preliminary review of the material submitted, OFIR accepted the request for external review.

This case involves medical issues. Therefore, the matter was assigned to an independent medical review organization which submitted its analysis to OFIR on November 22, 2010.

II FACTUAL BACKGROUND

Petitioner is a 47 year-old male with a history of Parkinson's disease. In addition, he has head and spine injuries from a car accident 13 years ago. Due to these conditions, Petitioner receives in-home physical therapy services. Petitioner submitted to PHP a claim for treatment received from XXXXX for the period January 1 through August 31, 2010. XXXXX are not in the PHP network of providers. PHP denied coverage.

The Petitioner appealed the denial through PHP's internal grievance process and received its final adverse determination letter dated October 12, 2010.

III ISSUE

Did PHP properly deny the Petitioner coverage for in-home physical therapy sessions under the terms of the certificate of coverage?

IV ANALYSIS

Petitioner's Argument

In his request for external review, Petitioner explained:

XXXXX provides out patient therapy to myself averaging 2 times a week. This service has significant impact on my well being. This covered service has not been paid for since January 2010 through October. Internal grievance declared criteria for coverage was not met.

In a letter dated August 24, 2010, in support of Petitioner's in-home physical therapy, Petitioner's therapist XXXXX wrote:

[Petitioner] . . . has an incomplete spinal cord injury, a head injury and Parkinson's disease. Although he is able to leave his home, community mobility is at times challenging and fatiguing. In addition he was having safety and mobility issues pertaining to his ability to ambulate in his home. We found that treating [Petitioner] in his home enabled us to develop effective mobility strategies that are specific to his environment which reduced the barriers and increased his safety.

Petitioner contends he meets the criteria for coverage to receive in-home physical therapy. Therefore, he wants PHP to provide coverage.

Respondent's Argument

In its October 12, 2010, final adverse determination PHP wrote, “your benefits do not include coverage for physical therapy in the home when criteria are not met. To meet criteria, you must show documentation of homebound status.”

In support of its ruling, PHP cited two provisions in the Petitioner's certificate of coverage: section 2(Q)(1) which excludes coverage for “[h]ealth services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 10: Glossary of Defined Terms.” The second provision, from section 10 of the certificate, defines “covered health service” as:

those health services, including services, supplies, or Pharmaceutical Products, determined to be Medically Necessary per PHPMM medical policy and nationally recognized guidelines and which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: What's Covered – Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: What's Not Covered – Limitations and Exclusions.

* * *

Commissioner's Review

The Certificate and medical policy provides coverage for in-home therapy when criteria to meet homebound status are met. The certificate includes the following provision:

Section 1: What's Covered – Benefits

* * *

26. Rehabilitation Services – Outpatient Therapy

* * *

Any combination of Network and Non-Network Benefits for any combination of physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation therapy is limited to 60 visits per calendar year.

In its final adverse determination, PHP did not reference any specific standards for physical therapy. In the material PHP submitted to the IRO, however, PHP cited “Milliman Care Guidelines” for home health care which includes guidance in determining whether a patient is homebound:

Patients considered to be homebound are those normally unable to leave home because an illness or injury restricts their ability to leave their place of residence without a considerable and taxing effort. This generally includes the use of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave the home.

The questions of Petitioner’s “homebound” status and the necessity of in-home physical therapy were submitted to an independent medical review organization (IRO) pursuant to section 11(6) of PRIRA, MCL 550.1911(6). The review was conducted by a physician who is board certified in physical medicine and rehabilitation; holds an appointment at an academic medical center, and has been in practice for more than 15 years. The IRO reviewer examined the medical records and other materials submitted by Petitioner and PHP. The IRO reviewer’s report included the following conclusions:

[D]ue to the member’s difficulty in leaving his home due to his Parkinson’s disease, he met the homebound criteria according to Medicare. . . . [T]he in-home physical therapy services that the member received from January 2010 to August 2010 were medically necessary for treatment of his condition, but future in-home physical therapy services are not medically necessary for treatment of his condition at this time.

The Commissioner is not required in all instances to accept the IRO’s recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite “the principal reason or reasons why the Commissioner did not follow the assigned independent review organization’s recommendation.” MCL 550.1911(16)(b). The IRO’s analysis is based on extensive experience, expertise and professional judgment, and is supported by literature. The Commissioner can discern no reason why the IRO’s recommendation should be rejected in the present case. The Commissioner accepts the conclusion of the IRO and finds that PHP’s denial

of in-home therapy was not consistent with the terms of the certificate.

The Commissioner notes that this decision is only applicable to the therapy dates in question. The IRO reviewer found that medical necessity for additional in-home therapy had not been established. In addition, PRIRA reviews are retrospective in nature and require that an individual first complete an insurer's internal grievance process following a denial of benefits. The Commissioner cannot require PHP to approve therapy for any dates in the future since eligibility for coverage in the future is dependent on Petitioner continuing to meet the standards found in the certificate of coverage.

V
ORDER

The Commissioner reverses PHP's denial of coverage for the January 1 through August 31, 2010, dates of service. PHP shall provide coverage within 60 days of the date of this Order and, within seven days of providing coverage, shall provide the Commissioner with proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free at (877) 999-6442.

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

Ken Ross
Commissioner