

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 118245-

001

v

Assurity Life Insurance Company
Respondent

Issued and entered
this 27th day of April 2011
by R. Kevin Clinton
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 29, 2010, XXXXX, on behalf of his minor son 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.* On December 2, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The Commissioner notified Assurity Life Insurance Company (Assurity) of the external review and requested the information used in making its adverse determination. The information was received on December 9, 2010.

The Petitioner receives health care benefits as an eligible dependent under an association group plan underwritten by Assurity. The issue here can be decided by applying the terms of the Petitioner's health care policy. The Commissioner reviews contractual issues under MCL

500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in Assurity's certificate of group insurance (the certificate). Assurity furnished a copy of the certificate.

From March 8 through August 26, 2010, the Petitioner received speech therapy from a non-participating provider. Assurity initially denied coverage for the therapy but subsequently determined that the visits should be treated as eligible expenses. However, after Assurity applied a deductible and maximum visit limitation, the Petitioner was responsible for the entire covered amount of the therapy.

The Petitioner appealed the handling of the claims for the speech therapy through Assurity's internal grievance process. Assurity upheld its original decision and issued a final adverse determination dated October 25, 2010.

III ISSUES

Did Assurity properly apply the terms of Petitioner's certificate in processing the claims for his speech therapy?

IV ANALYSIS

Petitioner's Argument

The Petitioner, born April 29, 2008, has been diagnosed with severe verbal apraxia; he had difficulty with verbal communication. In March 2010 he began speech therapy with an out-of-network provider. Group Marketing Services (GMS), acting for Assurity, denied all coverage for the speech therapy, saying it was not a benefit under his health care plan. Later GMS decided that it

was a covered benefit but applied the out-of-network deductible¹ and also limited the number of visits.

The Petitioner's father argues that the therapy should be treated as a network service because the provider had applied to be part of Assurity's network in April 2010 but was prevented from joining until August 2010 because of "administrative" delays with its application.

The Petitioner's father also argues that Assurity was wrong to limit the visits to a period of 60 consecutive days; he says that the Petitioner's condition could not be appropriately addressed in such a short period and believes the certificate permits treatment up to 12 months.

Respondent's Argument

In its October 25, 2010, final adverse determination, Assurity explained its reason for limiting the speech therapy benefit:

The maximum benefits [sic] for outpatient...speech therapy is 60 consecutive days limit per 12 month period beginning with the first date of treatment. It is NOT 60 consecutive days or 12 months. The 60 consecutive days started with the first treatment on March 8, 2010 and ended May 7, 2010, the end of the 60 consecutive days.

Assurity also noted that out-of-network speech therapy is paid at 60% after the out-of-network deductible (\$5,000.00) has been met. Regarding the network status of the provider, Assurity said:

[The speech therapy provider] was not a participating provider until August 15, 2010. Unfortunately, we do not have any control as to when a provider becomes Participating. There is a proper credentialing and contracting process that is done by your selected PPO (Cofinity) Network. It was understood this provider was Out-Of-Network when [the Petitioner's mother] contacted our office in March [2010], prior to the treatment, she was told that the charges would be applied to the \$5000 Out-Of-Network Deductible. She understood and said that was fine, she just wanted the treatment to be considered as an Eligible Expense.

Assurity maintains that the claims for speech therapy were properly processed under the

¹ The individual out-of-network deductible is \$5,000.00; the individual network deductible is \$1,000.00.

terms and conditions of the certificate.

Commissioner’s Review

It is undisputed that the provider was not in Assurity’s network at the time the Petitioner began the speech therapy. In his undated letter accompanying the request for external review, the Petitioner’s father quotes the provider as saying that it did not begin the process of enrolling in the network until May 2010; Assurity says the provider did not actually join the network until August 15, 2010. Thus, any services provided to the Petitioner up to August 15, 2010, could be subject to the \$5,000.00 individual annual out-of-network deductible. There is nothing in the certificate or in state law that requires Assurity to make network status retroactive for any reason. It is the provider’s network status on the date of service that determines whether the service is in or out of network.

The second issue is the limitation on the speech therapy benefit. The certificate’s schedule of benefits describes the limitation (p. 5):

OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	(Out-of-Network)	In-Network
60 Consecutive Day Limit / 12 month period Prior Approval Required, Call (800) 238-1602	60% to Coinsurance Limit after Deductible	100% - \$25 Copay

This provision offers scant information about the limitation or how it works.² The Petitioner’s father interprets the phrase “60 Consecutive Day Limit / 12 month period” to mean that the benefit is available for a 60 consecutive day period **or** for 12 months. The Commissioner disagrees with that interpretation – it does not make sense that a limitation would be expressed as either 60 consecutive days or 12 months since a 60 consecutive day period would be included in any 12 month period. Moreover, there is a similar limitation in the certificate (p. 31) for the physiotherapy benefit where it more clearly says “sixty consecutive days limit in a 12 month period.”

While the provision is poorly drafted, the Commissioner’s interpretation is the same as

² The Commissioner could find nothing in the certificate that describes or explains the outpatient physical, occupational, or speech therapy benefit or its limitation other than this entry.

Assurity's: once any physical, occupational, or speech therapy begins, the benefit ends after 60 consecutive days and does not renew until a new 12 month period begins. According to the explanation of benefits forms, the Petitioner's first speech therapy visit was March 8, 2010. Therefore, only visits through May 7, 2010, would be considered as eligible expenses. The explanation of benefits forms shows that the eligible expenses for all speech therapy visits up to May 7, 2010, were applied to the out-of-network deductible and since that deductible had not been satisfied by May 7, 2010, Assurity made no payment for any of the speech therapy visits.

The Commissioner finds that the Petitioner received speech therapy from an out-of-network provider beginning March 8, 2010, and that his speech therapy benefit ended on May 7, 2010. The Commissioner further concludes and finds that Assurity processed the Petitioner's claims correctly according to the terms and conditions of the certificate.

V
ORDER

The Commissioner upholds Assurity Life Insurance Company's October 25, 2010, final adverse determination.

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.

R. Kevin Clinton
Commissioner

