

STATE OF MICHIGAN
DEPARTMENT 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. 118100-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 30th day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On November 16, 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 Commissioner reviewed the request and accepted it on November 23, 2010.

The Commissioner notified Blue Cross 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 7, 2010.

The issue in this external review can be decided by a contractual analysis. The contract that defines the Petitioner's health care benefits is the BCBSM *Community Blue Group Benefits Certificate* (the certificate). 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 March 1 to May 6, 2010, the Petitioner received occupational therapy (OT) services from XXXXX in XXXXX, where she resides. XXXXX is a freestanding facility that does not participate with BCBSM. The charge for the therapy was \$3,445.00.

BCBSM denied coverage on the basis that OT from a nonparticipating, freestanding facility is not a benefit.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on September 16, 2010, and issued a final adverse determination dated September 20, 2010, upholding the denial.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's OT services at XXXXX?

IV. ANALYSIS

Petitioner's Argument

In December 2009 the Petitioner fell and broke her wrist. After receiving medical treatment, the Petitioner was directed to seek therapy and XXXXX was recommended to the Petitioner by an orthopedics therapy technician because XXXXX was known to be particularly good with wrists. Moreover, XXXXX was located only five blocks from the Petitioner's home.

The Petitioner says she asked XXXXX to contact BCBSM to confirm that the therapy would be covered, which she says XXXXX did. However, weeks into therapy BCBSM denied coverage, indicating to XXXXX that the therapist was not an approved therapist. When the Petitioner challenged the denial, she says BCBSM gave many reasons why the therapy would not be covered.

In her final appeal she was told that her therapist was approved but, because the facility was freestanding, the therapy was not a covered benefit.

The Petitioner believes that she followed the guidelines to have the therapy covered but received misleading information from BCBSM. She believes BCBSM should be required to pay for the therapy.

BCBSM's Argument

BCBSM indicates it administers health care benefits pursuant to the contract language and there are specific criteria for OT services under the certificate. BCBSM cites this provision in Section 3 (p. 3.28):

Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other facility independent of a hospital or an independent sports medicine clinic.

The certificate (p. 7.9) defines "Freestanding Outpatient Physical Therapy Facility" as:

An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

In "Section 4: Coverage for Physician and Other Professional Provider Services," the certificate states (p. 4.14):

We pay physician¹ services for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation. [Underlining added]

BCBSM states that XXXXX is not a participating freestanding outpatient physical therapy facility. Furthermore, the certificate does not provide for direct reimbursement to occupational therapists. OT services performed in an office setting must be billed by the physician who employs the certified registered occupational therapist; the Petitioner's services were not billed by a physician.

Based on the claims submitted and the language of the certificate, BCBSM states the Petitioner's OT services were correctly denied.

1 The certificate (p. 7.19) defines "physician" as "a doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon."

In response to the Petitioner's argument that she was misled, BCBSM states XXXXX called on February 23, 2010, and was correctly informed that the Petitioner had a benefit for OT for up to 60 visits per calendar year subject to any applicable deductible requirements. Because it is not possible to determine exactly what questions XXXXX asked, BCBSM states it is difficult to know if indeed erroneous information was given. Nevertheless, BCBSM states its claims determinations are based on the language of the certificate and the OT services provided in this case are not a benefit.

Commissioner's Review

The certificate makes a distinction between OT services provided through a facility (Section 3) and OT services provided in a physician or other professional provider's office (Section 4).

Section 3 of the certificate, "Coverage for Hospital, Facility and Alternatives to Hospital Care," quoted above, states that OT services are not payable when provided by a nonparticipating freestanding outpatient physical therapy facility or any other facility independent of a hospital or an independent sports medicine clinic.

Section 4 of the certificate, "Coverage for Physician and Other Professional Provider Services," indicates that OT services provided by a "physician" is a covered benefit. The certificate, however, defines a physician as a doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon.

Based on the language in Section 3 of the certificate, OT services from XXXXX are not covered because XXXXX is not a participating freestanding outpatient physical therapy facility. No information was provided to establish that XXXXX participates with BCBSM or any XXXXX Blue Cross Blue Shield plan. Moreover, nothing in the record shows that the Petitioner's OT services were provided or billed by a physician as required by Section 4 of the certificate. Therefore, the Petitioner's therapy at XXXXX is not covered under the terms of the Petitioner's certificate.

Finally, the Petitioner believes that BCBSM provided erroneous information about her OT benefits, indicating that her therapy would be covered; BCBSM does not believe it provided misleading information. The Commissioner cannot resolve this type of dispute.

The Patient's Right to Independent Review Act (PRIRA) provides for only a limited "paper" hearing. *English v Blue Cross Blue Shield of Michigan*, 263 Mich App 449 (2004). Under PRIRA, the Commissioner cannot conduct the kind of fact-finding that would be needed to support or refute the Petitioner's contentions. In addition, the Commissioner lacks the authority to base a decision on doctrines such as reliance or estoppel. The Commissioner's role is limited to determining whether a health plan has administered health care benefits under the terms of the applicable insurance contract and state law. The Petitioner's issue may be resolved in another forum. The Commissioner's decision in this matter does not preclude the Petitioner from seeking other remedies available under state law. See MCL 550.1915(3).

The Commissioner concludes and finds that the certificate precludes coverage for the OT services provided at Excel Therapy Specialists from March 1, 2010 to May 6, 2010.

V. ORDER

BCBSM's final adverse determination of September 20, 2010, is upheld. BCBSM is not required to pay for occupational therapy services provided to the Petitioner from March 11, 2010 through May 6, 2010.

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

R. Kevin Clinton
Commissioner