

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

Physical Therapy & Fitness Plus, Inc.
Clinic for Functional Physical Therapy, Inc.
James Creps Physical Therapy, PC
Body Mechanix Physical Therapy, LLC
L.B. Physical Therapy, Inc.,

Petitioners

Docket No. 2010-1005
Case No. 10-796-BC

v

Blue Cross Blue Shield of Michigan,

Respondent

Issued and entered
this 20th day of April 2012
by R. Kevin Clinton
Commissioner

FINAL DECISION

This case concerns an audit by Blue Cross Blue Shield of Michigan (BCBSM) of several of its participating providers. Based on its audit findings, BCBSM concluded it had overpaid the providers during the audit period, April 2004 through December 2005.

The providers disputed BCBSM's audit findings. A Review and Determination proceeding was held by the Commissioner's designee¹ who concluded that BCBSM had violated section 402(1)(c) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(c). The Commissioner's designee also concluded that BCBSM was not entitled to recover all the funds it sought.

The decision was appealed to the Commissioner by BCBSM. A contested case hearing was scheduled. Prior to the hearing, on October 31, 2011, Petitioners filed a motion for summary decision. A response was filed by BCBSM.

In a Proposal for Decision (PFD) issued February 8, 2012, the administrative law judge (ALJ) recommended that the October 31 motion for summary decision be granted.

1. See MCL 550.1404.

The ALJ also recommended that the Commissioner find that BCBSM did not violate Act 350. Neither party has filed exceptions to the PFD.

The parties stipulated to a set of uncontested facts which are stated in the PFD. The conclusions of law in the PFD are based on those facts and are supported by reasoned opinion. The PFD is attached, adopted, and made part of this final decision.

ORDER

It is ordered that:

1. The Petitioners' October 31, 2011 motion for summary decision is granted.
2. BCBSM may not recover the funds it sought from the Petitioners.
3. BCBSM, in the conduct of its audit, did not violate any provision of Act 350.



R. Kevin Clinton
Commissioner

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

In the matter of	Docket No.	2010-1005
Physical Therapy & Fitness Plus, Inc. Clinic for Functional Physical Therapy, Inc., James Creps Physical Therapy, P.C., Body Mechanix Physical Therapy, LLC, L.B. Physical Therapy, Inc., Petitioners	Agency No.	10-796-BC
	Agency:	Office of Financial & Insurance Regulation
	Case Type:	Appeal Subscriber/Provider
v		
Blue Cross and Blue Shield of Michigan, Respondent		

Issued and entered
this 8th day of February, 2012
by Renee A. Ozburn
Administrative Law Judge

**PROPOSAL FOR DECISION GRANTING SUMMARY DECISION
AND ORDER CANCELLING HEARING**

PROCEDURAL HISTORY

Blue Cross Blue Shield of Michigan (BCBSM/Respondent) conducted a post-payment audit of physical therapy services provided by the above named physical therapy providers (Petitioners). As a result of the audit, BCBSM demanded a refund of certain payments made for services delivered to patients between February 1, 2005 and September 30, 2006. Petitioners appealed the demand for refund through internal BCBSM processes and the Office of Financial and Insurance Regulation (OFIR) Review and Determination process. The Review and Determination decision issued on June 30, 2010 concluded that although BCBSM violated Sections 402(1) and 403 of, the Nonprofit Health Care Corporation Reform Act, (Act), 1980 PA 350, MCL 550.1101, *et seq.*, Petitioner's still owed a refund. Petitioners filed a request for a contested case hearing asserting that

BCBSM is not entitled to any refund. On September 30, 2010, OFIR issued an Order Referring Complaint for Hearing and Order to Respond.

A prehearing was conducted on November 9, 2010. Attorneys Alan Rogalski and Deborah Williamson appeared on behalf of Petitioners. Attorney Bryant Greene appeared on behalf of Respondent BCBSM. On November 17, 2010 an Order Following Prehearing Conference was issued.

On January 21, 2011, Petitioners filed a Motion for Summary Decision asserting that there was no genuine issue of material fact in dispute. On January 28, 2011, BCBSM filed a Response to Motion to Dismiss. On February 4, 2011, Petitioners filed a Response to BCBSM's Response. An Order Denying Summary Decision was issued on February 14, 2011.

A hearing was scheduled for March 2011 and subsequently adjourned to November 2, 2011. On October 31, 2011, Petitioners filed a Second Motion for Summary Decision. The November 2, 2011 hearing was converted to a telephone prehearing. An Order Following Telephone Prehearing was issued on November 7, 2011 scheduling the hearing to begin on February 22, 2012. On December 2, 2011, Respondent filed a Response to Petitioner's Second Motion for Summary Decision. Petitioners filed a Reply to Respondent's Response on December 21, 2011.

ISSUES AND APPLICABLE LAW

The basis of Petitioner's Second Motion for Summary Decision is a Final Decision issued by the Commissioner on June 29, 2011 in the matter of *Internal Medicine Associates of Mt. Clemens and Jerome Finkel, M.D. v Blue Cross Blue Shield of Michigan*, Case No. 10-763-BC. The underlying facts of *Internal Medicine* included BCBSM's payment of claims after assuring providers that BCBSM's website and its

publication "*The Record*" were both valid sources for determining benefit eligibility criteria. In *Internal Medicine*, the website and "*The Record*" provided different criteria and BCBSM paid provider claims that were valid under only the website's criteria. After conducting an audit, BCBSM sought to recover payments using benefit criteria provided in *The Record*. The Final Decision in *Internal Medicine* held that BCBSM's payments were made in accordance with valid benefit criteria from the website and were not "mistaken payments".

In the present matter, BCBSM affirmed claims and made timely payments for services provided to Petitioners physical therapy patients. The parties have stipulated that Petitioners utilized all available BCBSM resources for verifying eligibility criteria at the time claims were submitted. After an audit, BCBSM sought to recover payments asserting that the verification system provided incorrect eligibility information due to an editing failure that BCBSM failed to discover for over 5 years.

In Petitioner's January 21, 2011 initial Motion for Summary Decision and the resulting Order Denying Summary Decision issued on February 14, 2011, the issue was framed as whether BCBSM could recover a mistaken payment if Petitioners detrimentally relied on the payment. Pursuant to the Commissioner's June 2011 *Internal Medicine* decision, Petitioners' October 31, 2011 Second Motion for Summary Decision reframes the issue as whether BCBSM can recover payments that were consistent with applicable benefit criteria at the time they were paid.

The September 30, 2010, Order Referring Complaint for Hearing and Order to Respond in this matter, cites Section 402(1)(a),(b),(c),(d),(e),(f),(l) & (m) and Section 403(1) as the applicable law for purposes of the contested case. These Sections provide as follows:

Sec. 402.

(1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.

Sec. 403.

(1) A health care corporation, on a timely basis, shall pay to a member benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim. Section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006, applies to a health care corporation.

FINDINGS OF FACT

The parties have stipulated to the following uncontested facts:

1. Petitioners are providers of physical therapy health care services.
2. Petitioners sought payments from BCBSM for services delivered to patients in accordance with the rights and procedures spelled out in the Physician and Professional Provider Participation Agreements entered into between BCBSM and the individual Petitioners.
3. Petitioners followed all known and available BCBSM procedures to obtain verification that services were covered and amounts of coverage were correct before submitting claims.
4. BCBSM paid providers for individually billed physical therapy services during the period February 1, 2005 through September 30, 2006, using a maximum daily fee determined by BCBSM.
5. After a February 2007 BCBSM audit of payments to Petitioners for the period February 1, 2005 through September 30, 2006, BCBSM notified Petitioners that a BCBSM system error, in place since 2000, resulted in overpayments to individual Petitioners of the maximum daily fee for the audited period. BCBSM requested repayment of different amounts from individual Petitioners. Adjustments were made to the individual refund requests after Managerial Level Conferences (MLC) were held with each Petitioner.
6. Petitioners consolidated their appeals of the refund requests and sought an OFIR Review and Determination decision.
7. The Review and Determination decision issued by an Insurance Commissioner's Designee on June 30, 2010 concluded that BCBSM violated Sections 402(1)(c) of the Act by failing to adopt and implement reasonable standards for the prompt investigation of a

claim arising under a certificate when its refund request was not pursued in a timely manner, causing Petitioners to detrimentally rely upon such payments when computing tax consequences of such payments. The Commissioner's Designee's made an allowance of 40% and adjusted the collective amount owed by Petitioners to BCBSM down to \$286,655.36.

CONCLUSIONS OF LAW

There is no factual dispute that Petitioners submitted claims for services eligible for coverage under published applicable benefit criteria. In addition, there is no factual dispute that Respondent BCBSM paid claims based on those applicable benefit criteria in a timely manner. BCBSM asserts that a "system error", dating back to 2000, caused it to publish the wrong applicable benefit criteria. In addition, BCBSM contends that it should be able to correct the mistake and recover overpayments and that Petitioners must show evidence of detrimental reliance to negate recovery .

BCBSM cites the Commissioner's ruling in *Kilpatrick, et al v BCBSM*, 04-394-BC (2005) as the basis of its right to pursue recovery through an evidentiary hearing. In *Kilpatrick*, although the Commissioner determined that a computer mistake resulted in overpayments, the payments were not recoverable because providers relied to their detriment on the claims being correctly paid. Respondent BCBSM asserts that the "system error" in the present matter was a mistake analogous to the computer error in *Kilpatrick* and constitutes a mistake that triggers an inquiry into whether Petitioners detrimentally relied on payments that resulted from the mistake. Determining detrimental reliance is an issue of material fact that must be established through an evidentiary hearing.

The Commissioner's *Internal Medicine* decision articulates new standards for assessing what constitutes a mistake that would require a showing of detrimental reliance

by a provider. The Commissioner notes that under the Provider Participation Agreement, BCBSM's right to recover is qualified as follows:

"BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary..."

In *Internal Medicine*, the Commissioner determined that payments consistent with published benefit criteria do not constitute a "mistake".

When the Commissioner's reasoning from the *Internal Medicine* decision is applied to this matter, it is clear that BCBSM did not make a mistake and it can not recover under the Agreement. BCBSM paid for services meeting applicable benefit criteria and there is no need to explore the question of detrimental reliance.

In addition, there has been no violation of the applicable Sections of 402(1) and 403(1) cited in the September 2010 Complaint, because BCBSM timely paid claims consistent with published benefit criteria.

Petitioners have presented cogent and persuasive argument establishing that detrimental reliance is not a genuine issue of material fact in this matter. The parties have stipulated to all other genuine issues of material fact. There being no further material facts at issue, Petitioner's Second Motion for Summary Decision, dated October 31, 2011, should be granted.

PROPOSED DECISION

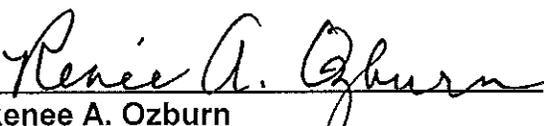
Pursuant to the above Findings of Fact and Conclusions of Law, the undersigned Administrative Law Judge recommends that the Commissioner issue a Decision and Order that BCBSM is not entitled to recover any amounts claimed as overpayments in this matter.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Office of Financial and Insurance Regulation, Division of Insurance, Attention: Dawn Kobus, P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of issuance of this Proposal for Decision. An opposing Party may file a response within ten (10) days after Exceptions are filed.

ORDER CANCELLING HEARING

Pursuant to the above Proposed Decision, **IT IS ORDERED** that the hearing scheduled for February 22, 2012, is **CANCELLED**.



Renee A. Ozburn
Administrative Law Judge