

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████

Petitioner,

v

File No. 151259-001

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 8th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner), a minor,¹ was denied coverage for speech therapy by his health care insurer, Blue Cross Blue Shield of Michigan (BCBSM).

On December 10, 2015, ██████████, the Petitioner's mother, filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the information submitted, the Director accepted the request on December 17, 2015.

The Petitioner receives health care benefits as an eligible dependent through an individual plan underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM provided its response on December 29, 2015.

The issue here can be resolved by the Director without the need for a medical review by an independent review organization. MCL 550.1911(7).

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Blue Cross Premier Gold Benefits*

¹ ██████████

*Certificate*² (the certificate).

The Petitioner has been diagnosed with autism. Between January 3 and December 30, 2014, he received speech and language pathology services for that condition. BCBSM covered the first 30 therapy visits but denied coverage for the 53 subsequent visits on and after May 16, 2014, saying they exceeded the benefit maximum of 30 visits per calendar year. The charge for the non-covered visits was \$7,420.00.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of that process, BCBSM affirmed its decision in a final adverse determination dated November 5, 2015. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for speech therapy services after 30 visits?

III. ANALYSIS

Petitioner's Argument

Included with the external review request was a member appeal form dated September 14, 2015, that the Petitioner's father submitted to BCBSM. It explained the Petitioner's appeal:

We are requesting reimbursement for our son[']s . . . speech therapy services. 53 visits from 5/16/14 through 12/30/2014 were not paid due to number of visits limitations set forth by BCBS. [Our son] has a 299.0 [*diagnosis code for autism disorder*] with corroborating neurological & multidisciplinary assessment. . . . Michigan state laws . . . states that insurers are required to reimburse family's \$40,000/yr for children ages 7-12.

BCBSM's Argument

In its final adverse determination, BCBSM's representative explained why coverage was denied:

. . . After careful review, I confirmed that [the Petitioner] continued to receive speech therapy services after he had reached his benefit maximum of 30 visits. Therefore, the claims denied appropriately. You remain responsible for the non-covered charges totaling \$7,420.00.

At the time services were rendered, [the Petitioner] was covered under the *Blue Cross Premier Gold Benefits Certificate*. Pages 22 and 23, (*Section 3: What BCBSM Pays For*), explain that we pay for speech and language pathology services for the treatment of

² BCBSM form no. 604F, federal approval 09/13; state approval 03/14.

autism. However, the services are subject to visit limitations. Page 98 explains that we pay for a maximum of 30 outpatient visits per member per calendar year.

[The Petitioner's] provider submitted claims for 83 dates of service with procedure code 92507 (speech/hearing therapy; individual). According to the Benefit Package Report (BPR), which is an online tool used by BCBSM to house procedure specific group benefits information, 92507 is classified as a speech and language pathology / therapy service. Thus, visit maximums apply to this service.

According to our records, we paid for 30 speech therapy visits reported with service dates from January 3, 2014, to May 13, 2014. Therefore, claims for speech therapy services [the Petitioner] received after May 13, 2014, were correctly denied in accordance with his coverage provisions. As a result, no further benefit is warranted.

In your appeal letter, you explained that you should be reimbursed for [your son's] services under the annual dollar maximum provision of the Michigan Autism Mandate. I understand your position. However, in 2014 the federal Affordable Care Act (ACA) did not permit insurance companies to impose annual or lifetime dollar maximums, but did permit visit limitations for services to treat autism.

BCBSM is required to comply with both federal and state laws. Because we must also comply with federal law, we removed the dollar maximum, but applied the therapy visit maximum, which applies to all rehabilitative and habilitative services per ACA requirements for the Ten Essential Health Benefits mandated by the act. Because we are bound by regulatory requirements and the terms of coverage, we are unable to consider any further benefits for your son's therapy.

Please note, in 2015 federal law was revised under the ACA to remove both annual or lifetime dollar maximums and visit limitations for the treatment of autism.

I understand that the outcome of my review is not favorable to you. However, please be assured that all consideration has been given. I am unable to make an exception on [your son's] behalf.

Director's Review

There is no dispute that the Petitioner's speech therapy was treatment for an autism spectrum disorder. The issue in this case is whether BCBSM can limit the Petitioner's autism-related speech therapy to 30 visits in calendar year 2014. To decide the issue, the Director must reconcile provisions in state and federal law.

Treatment of autism spectrum disorders is a required benefit under section 3406s of the Insurance Code, MCL 500.3406s, which says in part:

(1) Except as otherwise provided in this section, an expense-incurred hospital, medical, or surgical group or individual policy or certificate delivered, issued for delivery, or renewed in this state and a health maintenance organization group or individual contract

shall provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders. An insurer and a health maintenance organization shall not do any of the following:

* * *

(b) Limit the number of visits an insured or enrollee may use for treatment of autism spectrum disorders covered under this section.

(c) Deny or limit coverage under this section on the basis that treatment is educational or habilitative in nature.

(d) Except as otherwise provided in this subdivision, subject coverage under this section to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. Coverage under this section for treatment of autism spectrum disorders may be limited to an insured or enrollee through 18 years of age and may be subject to a maximum annual benefit as follows:

(i) For a covered insured or enrollee through 6 years of age, \$50,000.00.

(ii) For a covered insured or enrollee from 7 years of age through 12 years of age, \$40,000.00.

(iii) For a covered insured or enrollee from 13 years of age through 18 years of age, \$30,000.00.³

Section 3406s allowed insurers to impose annual maximum dollar limits for the treatment of autism spectrum disorders but prohibited any limits on the number of therapy visits. However, the autism benefit in the Petitioner's certificate does include an annual visit limit. The autism benefit is defined in the certificate (pp. 21-23):

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified, as described below.

Covered Services

* * *

- **Therapeutic care.** It includes evidence-based physical therapy, occupational therapy, speech and language pathology, or other care performed by a licensed certified

³ Added by 2012 PA 100, effective April 18, 2012. The amendment applied to "policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 180 days after the date this amendatory act is enacted into law." A nearly identical provision is also found in section 416e of 1980 PA 350, as amended, MCL 550.1416e, the act that regulated BCBSM before it became a mutual insurance company. Section 416e was also effective April 18, 2012, and "applies to certificates delivered, executed, issued, amended, adjusted, or renewed in this state beginning 180 days after the date this amendatory act is enacted into law."

speech therapist, occupational therapist, physical therapist or social worker. Therapeutic care also includes nutritional therapy performed by a physician and genetic testing as recommended in the treatment plan.

* * *

Limitations and Exclusions

In addition to those listed in this certificate and any other riders that you may have, the following limitations and exclusions apply:

* * *

- Occupational therapy, physical therapy and speech and language pathology services for treatment of autism are subject to the visit limitations that apply to these services.

Regarding visit limitations for speech and language pathology services, the certificate says (p. 98):

We pay for a maximum of 30 outpatient visits per member per calendar year. This benefit maximum renews each calendar year. Important: This visit maximum is separate from that for occupational and physical therapy.

The federal Patient Protection and Affordable Care Act (PPACA)⁴ requires all non-grandfathered individual health insurance plans, like the Petitioner's, to provide coverage in ten categories of "essential health benefits." One of those categories is "rehabilitative and habilitative services" which includes speech therapy and other autism treatments. As BCBSM noted in its final adverse determination, PPACA prohibits the imposition of any annual or lifetime dollar limit on any essential health benefit, e.g., speech therapy. 42 USC § 300gg-11. Consequently, BCBSM did not include the maximum annual dollar limits permitted in section 3406s in the certificate's autism benefit because doing so would have been a violation of federal law. But BCBSM did include an annual 30 visit limitation in the certificate. The Director concludes that limitation is expressly prohibited by section 3406s(1)(b).

PPACA's prohibition on annual dollar limits was acknowledged in an order of the Commissioner of Financial and Insurance Regulation ("Order Requiring Coverage for Habilitative Services," Order No. 13-003-M, issued January 7, 2013). That order permitted health plans to mitigate the impact of the elimination of the maximum annual dollar limits permitted in section 3406s by imposing a limitation in a form other than a visit limit. Order No. 13-003-M allowed plans to:

convert the applicable dollar limits to non-quantitative (e.g., scope and duration) limits for any small group or individual plan offered on or after January 1, 2014. The converted non-quantitative limits must be actuarially justified and must be included in the form and rate filings submitted through the SERFF system for Commissioner review and approval.

However, for plan year 2014, BCBSM did not include any converted non-quantitative limits in

⁴ Public Law 111-148.

the form filing for the Petitioner's plan as a substitute for visit limits.⁵ Instead, it used visit limits, which are prohibited by section 3406s. Therefore, the Director concludes and finds that BCBSM could not limit the Petitioner's medically necessary speech therapy to 30 visits in 2014.⁶

V. ORDER

The Director reverses BCBSM's November 5, 2015, final adverse determination.

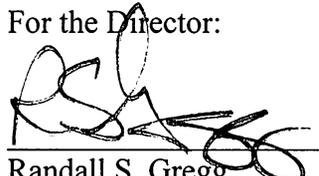
BCBSM shall immediately cover the Petitioner's medically necessary speech therapy visits from May 16 through December 30, 2014, subject to any applicable cost sharing requirements in the certificate. MCL 550.1911(17). BCBSM shall, within seven days of providing coverage, furnish the Director proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 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 60 days from the date of this order in the circuit court for the Michigan 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director

⁵ A subsequent order of the Director of the Department of Insurance and Financial Services, "Order Regarding Limits on Treatment for Autism Spectrum Disorders," Order No. 14-017-M, issued April 18, 2014, superseded that portion of Order No. 13-055-M that permitted the conversion of dollar limits to non-quantitative limits. That order limited the conversions to plan year 2014 and made clear that visit limits for autism treatment, even if expressed as hourly or daily limits, are prohibited in subsequent years, pursuant to Section 3406s.

⁶ The Director reached the same result in an earlier external review order regarding the Petitioner. See *Brizard v BCBSM*, File No. 150653-001, issued November 24, 2015.