

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. 145897-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 11<sup>th</sup> day of February 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On January 20, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the request was accepted on January 27, 2015.

The Petitioner is enrolled for health care coverage through an individual plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information it used to make its adverse determination. The Director received BCBSM's response on February 6, 2015.

The issue in this external review can be decided by a contractual analysis. The Director 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**

According to BCBSM, the Petitioner's health care benefits are defined in BCBSM's *Keep Fit and Member Edge Individual Market Certificate*<sup>1</sup> (the certificate). The certificate is amended

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<sup>1</sup> BCBSM form no. 351D, approved 10/12.

by Rider IOC \$7,500 / \$15,000-I, \$11,000 / \$22,000-O, #11,000 / \$22,000 OOPM Inpatient and Outpatient Cost-Sharing Requirements (the rider).

The Petitioner fell and broke her arm in August 2013. She subsequently had surgery on the arm in December 2013 and then began outpatient physical therapy in January 2014 at the [REDACTED], a panel provider. The therapy lasted until June 2014.<sup>2</sup>

The physical therapy the Petitioner received from January 24 through February 28, 2014, was at issue in an earlier external review under the Patient's Right to Independent Review Act. In that case the Director issued an order<sup>3</sup> holding that the physical therapy for that period was not subject to the annual deductible for panel provider services because it arose out of an accidental injury. BCBSM's explanation of benefit payments statement dated September 12, 2014, shows that those claims were reprocessed and paid 100% with no cost-sharing for the Petitioner.

The Petitioner continued to receive physical therapy at the [REDACTED] from March 7 through June 6, 2014. When those claims were processed, BCBSM applied its approved amount for the visits from March 7 through May 2, 2014, to the panel deductible and then denied coverage for all physical therapy visits after May 2 saying the Petitioner had reached the maximum number of visits allowed under the certificate.

The Petitioner appealed BCBSM's decision through its internal grievance process. At the conclusion of that process BCBSM issued a final adverse determination on December 12, 2014, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Were the claims for the physical therapy from March 7 through June 6, 2014, processed correctly?

### IV. ANALYSIS

#### Petitioner's Argument

The Petitioner wrote on January 20, 2015, as part of her external review request:

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<sup>2</sup> There is no dispute that all this therapy was related to the August 2013 accident. In its final adverse determination BCBSM did tell the Petitioner that it had "requested medical records from [REDACTED] on December 3, 2014 to confirm that the physical therapy you received on the referenced dates of service were related to your accidental injury." However, in its February 6, 2015, position paper submitted for this external review, BCBSM did not challenge the relatedness of the physical therapy to the Petitioner's accidental injury.

<sup>3</sup> [REDACTED] v Blue Cross Blue Shield of Michigan, file no. 142737, issued August 5, 2014.

. . . I submitted an appeal to the State of Michigan on July 11, 2014 for this matter. The State of Michigan responded on August 5, 2014 and ruled that Blue Cross was indeed responsible for the charges. However, I was not discharged from physical therapy until June of 2014. As a result, I did not yet have the total amount of charges incurred from physical therapy when I submitted the first appeal to the State of Michigan.

As stated above, my first appeal to the State of Michigan resulted in a ruling in my favor. When I inquired about how to handle the additional impending physical therapy charges, [I was] advised . . . to contact Blue Cross when I received the balance of the charges. As a result of the State's ruling in my first appeal, it was thought that Blue Cross would simply cover the additional physical therapy charges. However, Blue Cross requested that I file a second appeal for the additional charges which was in turn, denied. [BCBSM's] refusal to cover the remaining physical therapy charges is what prompts this second appeal to the State of Michigan.

#### BCBSM's Argument

In its final adverse determination on the physical therapy claims from March 7 through June 6, 2014, BCBSM explained to the Petitioner how it processed those claims:

You are covered under the *Keep Fit and Member Edge Individual Market Certificate*. On page 2.1 of your Certificate, under **Section 2: What You Must Pay, Deductible Requirements, Panel Providers** it states:

You are required to pay a deductible each calendar year for covered services provided by panel providers.

On page 4.14 of your Certificate, under **Section 4: Coverage for Physician and Other Professional Provider Services, Physician and Other Professional Provider Services That Are Payable, Physical, Speech and Language Pathology and Occupational Therapy Services** it states:

These benefits are payable for up to 12 visits for all therapies combined, per member, per calendar year. All visits for physical therapy, speech and language pathology services, and occupational therapy will count towards the benefit maximum regardless of who provides the services or where it is provided.

\* \* \*

On the referenced dates of service you had not satisfied your outpatient panel provider deductible requirement. Therefore, the allowed amount of \$605.60 was correctly applied to your outpatient panel provider deductible and you remain responsible for that amount.

Furthermore, I confirmed that on May 2, 2014 you reached your twelfth therapy visit for the calendar year. Therefore, the physical therapy services you received from May 6, 2014 to June 6, 2014 from [REDACTED] were not covered services and you remain responsible for the non-covered amount of \$947.00.

### Director's Review

In the earlier external review, the Director determined that the Petitioner's physical therapy from January 24 through February 28, 2014, was not subject to the annual deductible for outpatient panel services because it was indisputably related to an accidental injury and was rendered as an outpatient hospital service by a panel provider. That decision was based on this provision in the certificate (p. 2.1):

You are required to pay a deductible each calendar year for covered services provided by panel providers.

\* \* \*

The following covered services will not be subject to the panel deductible requirement:

\* \* \*

- Exam and treatment of an accidental injury and all covered services related to that injury rendered in the outpatient department of a hospital, urgent care center or a physician's office. [Underlining added]

The same rationale applies to the physical therapy on and after March 7, 2014; the certificate has not changed. While the rider amended the certificate to increase the cost-sharing requirement,<sup>4</sup> it did not change the provision in the certificate regarding the applicability of the panel deductible to accidental injuries. In fact, the rider (p. 3) affirms the certificate:

The only benefits that will not be subject to either the inpatient or outpatient deductible requirements will be the following:

\* \* \*

- Accidental injuries

BCBSM has offered no explanation as to why the reasoning of the Director's earlier order should not apply in this case. The Petitioner received outpatient physical therapy related to an accidental injury from a panel provider. Therefore, the Director concludes that any physical therapy from March 7 to June 6, 2014, is not subject to the calendar year deductible for panel

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<sup>4</sup> It increased the deductible for outpatient services from panel providers from \$1,000.00 to \$11,000.00 for a one-person contract.

services.

However, the certificate does not cover unlimited physical therapy. The certificate (pp. 4.13 - 4.14) has this provision under “Physical, Speech and Language Pathology and Occupational Therapy Services”:

We pay for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.

\* \* \*

These benefits are payable for up to 12 visits for all therapies combined, per member, per calendar year. All visits for physical therapy, speech and language pathology services, and occupational therapy will count towards this benefit maximum regardless of who provides the services (e.g., physicians or independent physical therapists) or where it is provided (e.g., outpatient hospital or freestanding outpatient physical therapy facility). The combined 12-visit therapy maximum is renewed each calendar year.

**NOTE:** An initial evaluation is not counted as a day of treatment. If approved it will be paid separately from the day of treatment and will not be applied to the 12-visit maximum.

There is no exception to the 12-visit limit, even if the therapy is required because of an accidental injury. Thus, BCBSM was only required to cover, at most, 12 physical therapy visits in calendar year 2014. BCBSM, in its final adverse determination, says that limit was reached on May 2, 2014.

Based on the foregoing, the Director concludes that BCBSM must cover any 2014 outpatient physical therapy visits with a panel provider that are related to the Petitioner’s August 2013 accidental injury without applying the panel deductible until the 12-visit limit is reached.

#### **V. ORDER**

The Director reverses BCBSM’s December 12, 2014, final adverse determination in part. BCBSM shall cover the claims for the Petitioner’s physical therapy from March 7 through May 2, 2014 (when the 12-visit limit was reached), without subjecting them to the panel deductible.

The Director upholds BCBSM’s denial of coverage for any therapy visits after May 2, 2014, through June 6, 2014.

BCBSM shall comply with this Order within 60 days of its date, and shall, within seven days of complying, furnish the Director with proof that it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, toll free at (877) 999-6442.

This is a final decision of an administrative agency. 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 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.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director