

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

In the matter of:

[REDACTED]
Petitioner

v

File No. 148916-001-SF

University of Michigan, Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

Issued and entered
this 13th day of August 2015
by Joseph A. Garcia
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 22, 2015, [REDACTED] (Petitioner) filed a request for external review with the Department of Insurance and Financial Services, appealing two claim decisions by Blue Cross Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan. The benefit plan is sponsored by the University of Michigan. The plan's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC* which is amended by *ASC Plan Modification 7676*.

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Petitioner's health benefit plan is such a governmental self-funded plan. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952).

On July 29, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the request and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on August 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

On May 6, 2015, three laboratory tests ordered by the Petitioner's doctor were processed by the Laboratory Corporation of America. The tests and the Laboratory Corporation of America's charges are listed below:

<u>Code #</u>	<u>Test Name</u>	<u>Charge</u>
82397	Chemiluminescent Assay	\$68.00
84443	Thyroid Stimulating Hormone (TSH)	\$46.52
86762	Rubella antibody	\$30.35

BCBSM denied coverage for these tests. The Petitioner's doctor resubmitted the claim for the TSH test using a different diagnosis code. BCBSM then provided coverage for that test but maintained its denial of coverage for the other two tests.

Between April 24 and May 14, 2015, the Petitioner received physical therapy services (an office visit and seven sessions of physical therapy) from the [REDACTED] BCBSM approved coverage for these services but applied copayments totaling \$180.00.

The Petitioner appealed BCBSM's denial of coverage for the laboratory services and its application of a copayment to the physical therapy services. The Petitioner completed BCBSM's internal grievance process and BCBSM issued a final adverse determination on July 6, 2015, affirming its position. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUES

Was BCBSM correct in denying coverage for the Petitioner's laboratory services?

Was BCBSM correct in applying a copayment to the Petitioner's physical therapy services?

IV. ANALYSIS

Laboratory Services

In its final adverse determination, BCBSM wrote:

You are covered under the *Community Blue Group Benefits Certificate ASC*. According to the plan's Benefit Package Report (BPR), which is the online tool used by BCBSM to house procedure specific benefit information for your plan, procedure codes 82397 (Chemiluminescent assay) and 86762 (Rubella) are only

payable for specific diagnoses listed under category 22/23 (routine/screening). In addition, procedure code 84443 (Thyroid stimulating hormone) is payable listed under category 22/23 (routine screening) or category 67 (Routine Newborn Care). In your case, the provider listed diagnosis code V7799 (Other and Unspecified endocrine, nutritional, metabolic and immunity disorders) and V733 (Rubella) which are not included under any of the payable diagnosis categories. As a result, we are unable to approved payment for the laboratory services.

In an August 6, 2015 email to the Department of Insurance and Financial Services, BCBSM stated that it had provided coverage for the thyroid stimulating hormone test once a revised claim had been submitted by the Petitioner's doctor. Therefore, the only laboratory tests that were denied coverage were the chemiluminescent assay and the rubella antibody. The amount charged for these services totaled \$98.35, not the \$144.87 cited in the final adverse determination.

In her appeal, the Petitioner wrote:

I called from the doctor office on 5/6/15 twice. I was hung up on and had to call back. I gave all of the procedure codes for the lab tests along with diagnostic code and was told all the lab tests were covered 100%. Once again, I would have not gotten these tests if I would have to pay out of pocket. I do not think this is fair; when I call your company and a representative gives out information, I assume it is correct and I make a decision based on that information. What is the point of calling to get coverage information to make health decisions if information is not correct? I should not be held accountable for mistakes that are not my own....

BCBSM denied coverage for the chemiluminescent assay and the rubella antibody because the University of Michigan group's coverage indicates these two procedures are not payable with the routine screening diagnosis codes used by the Petitioner's doctor. There is no indication in the Petitioner's appeal that BCBSM had mistakenly applied its coverage standards.

Physical Therapy Services

Effective on January 1, 2015, the Petitioner coverage changed to add a \$25.00 copayment requirement for physical therapy. This change was part of *Plan Modification 7676* which applied to the University of Michigan benefit plan. The pertinent part of *Plan Modification 7676* provides:

This modification ADDS a copayment requirement of \$25 per visit for physical, occupational and speech language pathology services by an in Network professional provider. In Network facility billed physical, occupational and

speech therapy language pathology services remain covered at 100% of the approved amount and are not subject to the \$25 copayment requirement.

In its final adverse determination, BCBSM wrote:

In regards to the physical therapy services you received April 24, 2015 through May 15, 2015, page 66 under **Section 3: What BCBSM Pays For** of the certificate explains that your health care plan covers a combined benefit maximum of 60 visits per member, per calendar year for physical therapy, occupational therapy and speech language pathology.

However, according to the BPR, your plan applies a \$25.00 copayment to the following procedures: procedure code 97001 (Physical therapy evaluation), 97110 (Therapeutic exercise, each 15 minutes) and 97140 Manual therapy techniques, 1 or more regions, each 15 minutes), procedure code 97035 (Ultrasound therapy), and procedure code 97014 (Electric stimulation therapy).

Further, a \$5.00 copayment was applied to your April 29, 2015 office visit (procedure code 99213). According to the BPR, your plan requires a \$30.00 copayment for procedure codes 99213 (office visit, est. patient) when performed by a specialist. Because a \$25.00 copayment was already applied to the physical therapy services you received the same day, the difference of \$5.00 was applied as your office visit copayment requirement.

In your appeal letter, you explained that on April 24, 2015 the provider was informed by a BCBSM Customer Service Representative that your physical therapy service would be covered 100% of the BCBSM approved amount. While I regret your provider may have received misleading information or incorrect information, as a Grievance and Appeals Coordinator for BCBSM, it is my responsibility to ensure that the claims at issue processed according to Plan Design. As a result, I cannot make an exception on your behalf. You remain liable for the copayment amounts totaling \$180.00.

The Petitioner's physical therapy services were performed in 2015 after the effective date of the benefit modification and were provided by a professional provider. Therefore the \$25.00 per visit copayment does apply. *Plan Modification 7676* also increases the copayment requirement to \$30.00 for office visits with in-network specialist physicians. The Petitioner's April 29, 2015 appointment included a specialist office visit so a \$30.00 copayment was applied. Therefore, the total copayments that apply to the Petitioner's physical therapy and specialist office visits was \$180.00 (\$25.00 each for six physical therapy visits and \$30.00 for the office visit).

The Petitioner argues that since BCBSM informed her and the provider that her physical therapy and laboratory services would be paid at 100 percent she should not be required to pay anything for those services.

In conducting reviews under PRIRA, the Director is limited to resolving question of medical necessity and determining whether an insurer's final adverse determination is consistent with the terms of the relevant policy or certificate of coverage. See MCL 550.1911(13). Even if the Petitioner was given inaccurate information regarding her benefits, the benefits are as written in the *Community Blue Group Benefits Certificate ASC* and *ASC Plan Modification 7676*. Under the PRIRA, the Director has no authority to amend the terms of an insurance policy to require BCBSM to provide coverage that is inconsistent with the Petitioner's actual benefits.

The Director finds that BCBSM's application of \$180.00 in copayments for the Petitioner's physical therapy services and the denial of coverage for the two laboratory tests were consistent with the terms of her benefit plan.

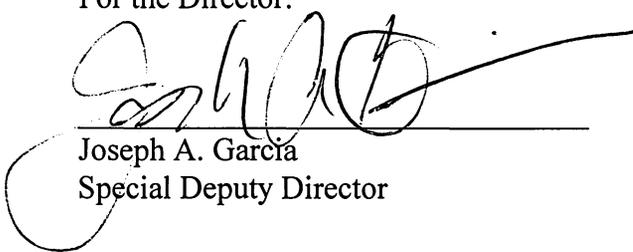
V. ORDER

The Director upholds BCBSM's denial of coverage for the Petitioner's laboratory tests and its copayment requirement for the Petitioner's physical therapy services.

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 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:



Joseph A. Garcia
Special Deputy Director