

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. 150077-001

Blue Cross Blue Shield of Michigan  
Respondent

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Issued and entered  
this 17<sup>th</sup> day of October 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On September 28, 2015, ██████████ (Petitioner) filed with the Director of Insurance and Financial Services a request for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on October 5, 2015.

The Petitioner receives health care benefits through a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are defined in BCBSM's *Blue Cross Premier Group Benefits Certificate*.

The Director notified BCBSM of the review and asked for the information used to make its final adverse determination. The Director received BCBSM's response on October 12, 2014.

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**

The Petitioner had shoulder surgery on April 20, 2015 to repair his rotator cuff. After the surgery, he began physical therapy and by June 24, 2015 he had received 30 physical therapy sessions. BCBSM processed and paid the claim for the June 24 therapy on July 3.

The Petitioner was examined on August 13, 2015 by his physician who prescribed additional therapy. BCBSM denied coverage for therapy claims received after July 3. The amount charged for the Petitioner's later therapy was \$1,823.00.

The Petitioner appealed the denial through BCBSM's internal grievance process. At the conclusion of this process, BCBSM issued its final adverse determination September 18, 2015 affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ISSUE

Is BCBSM required to provide coverage for the therapy the Petitioner received after June 24, 2015?

### IV. ANALYSIS

#### BCBSM's Argument

In its final adverse determination, BCBSM wrote to the Petitioner:

[Y]ou continued to receive therapy services after you had reached your benefit maximum of 30 visits. You have also exhausted your benefit for a physical therapy evaluation. Therefore, the claims denied appropriately, and no further payment from BCBSM is warranted.

You are covered under the *Blue Cross Premier Gold Benefits Certificate*. Page 69, (Section 3: What BCBSM Pays For), explains that we pay for a maximum of 30 physical therapy visits per member per year. The 30-visit maximum is a combined maximum for all therapy services, including physical therapy, chiropractic manipulations, osteopathic manipulative therapy, and occupational therapy. The combined 30-visit therapy maximum is renewed each calendar year.

Page 70 explains that each treatment date counts as one visit even when two or more therapies are provided. Initial evaluations are not counted as a visit and will not be applied towards the maximum benefit limit. Page 71 explains that we do not pay for more than 30 outpatient therapy visits per member per calendar year.

\* \* \*

According to our records, on July 3, 2015, BCBSM paid claim #28151812803900, for service date June 24, 2015, which was payment for your 30th therapy visit. Therefore, payments for therapy claims received after July 3, 2015, were correctly denied in accordance with your coverage provisions. To ensure all consideration was given, I reviewed all your denied therapy claims and confirmed that BCBSM did, in fact, receive the claims after July 3, 2015. As a result, you remain responsible for the non-covered billed charges of \$1,823.00.

...BCBSM does not dispute the necessity of your services. The claims are denied due to a benefit limitation that states we do not pay for more than 30 outpatient therapy visits per member per calendar year.

### Petitioner's Argument

In his request for an external review, Petitioner says he wants BCBSM to cover all past and future medically necessary PT. He understands the 30-visit limitation but argues because he did not get the follow-up PT he required after his surgery, he now needs more surgery and more PT. He believes it is better to cover the PT now rather than wait until 2016 when his benefits renew.

Petitioner argues the April 20, 2015 surgery should have reset his benefits and requests that BCBSM make an exception and cover the additional therapy visits now since they are medically necessary.

### Director's Review

The *Blue Cross Premier Gold Benefits Certificate (pages 69-70)*, describes the physical therapy benefits available to the Petitioner:

**We pay for:**

Medically necessary physical therapy services subject to the following:

\* \* \*

- A maximum of 30 outpatient visits per member per year.

Important: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic spinal manipulations and mechanical traction, and osteopathic manipulative therapy whether obtained from an in-network or out-of-network provider (see Note below about treatment dates and initial evaluations)...

**NOTE** Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

**NOTE** An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

BCBSM provided coverage for 30 visits of physical therapy. This coverage limit was reached with the June 24, 2015 therapy session, any physical therapy visits provided after that date would exceed the 30 visit benefit maximum for the calendar year. While the Petitioner may require more than 30 visits to treat his condition, BCBSM is not required to provide coverage for more than 30 therapy visits, even if they are medically necessary.

The Director finds that BCBSM's denial of coverage for the physical therapy received after June 24, 2015 was consistent with the terms of the *Blue Cross Premier Gold Benefits Certificate*.

**V. ORDER**

The Director upholds Blue Cross Blue Shield of Michigan's final adverse determination of September 18, 2015.

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 Department of Insurance and Financial Services, Office of General Counsel, P.O. Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin  
Director

For the Director

A handwritten signature in black ink, appearing to read 'RSG', is written over a horizontal line.

Randall S. Gregg  
Special Deputy Director