

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

In the matter of:

██████████
Petitioner

v

Blue Cross Blue Shield of Michigan
Respondent

File No. 150653-001

Issued and entered
this 24th day of November 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 30, 2015 ██████████, on behalf of her ██████ son ██████████ (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 Director accepted the request on November 6, 2015.

The Petitioner receives health care benefits through an individual plan underwritten by Blue Cross Blue Shield of Michigan Mutual Insurance Company (BCBSM). The benefits are defined in BCBSM's *Blue Cross Premier Gold Benefits Certificate*.

The Director 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 November 16, 2015.

II. FACTUAL BACKGROUND

The Petitioner is ten years old and has been diagnosed with autism. Between February 17, 2014 and December 8, 2014, he received treatment ██████████ (also known as Building Bridges Therapy) in ██████████. BCBSM provided coverage for some of the Petitioner's therapy sessions but denied coverage for other sessions provided between June 9 and December 8, 2014.

BCBSM informed the Petitioner's mother that, of the 46 claims filed for appeal with BCBSM's internal grievance process, 34 claims were not eligible for a grievance review because

they were filed more than 180 days after the initial claim denial. The Petitioner's mother did not appeal this portion of BCBSM decision to the Director. In order to qualify for external review, a denied claim must have passed through the insurer's complete grievance process. See section 7(2) of the Patient's Right to Independent Review Act, MCL 550.1907(2).

Based on BCBSM's uncontested conclusion that the 34 claims were untimely, the Director, in this order, will only consider the remaining 12 claims.¹ The claims are for one session of "therapeutic exercises to develop strength and endurance, range of motion and flexibility (CPT code #97110) and eleven sessions of "use of dynamic activities to improve functional performance" (CPT code #97530).² The total charge for these claims was \$1,155.00. BCBSM's total approved amount for the claims would be \$1,085.47.

At the conclusion of the grievance process, BCBSM affirmed its decision in a final adverse determination dated September 16, 2015.

III. ISSUE

Did BCBSM correctly deny coverage for the occupational therapy provided to the Petitioner?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner's mother wrote that they were appealing BCBSM's denial of coverage for occupational therapy at Building Bridges and requesting that BCBSM pay \$3,255.00 for the therapy:

Denial was based on BCBS visit limitations. Michigan state law states that no insurance company can limit services to an eligible autism client. There are only monetary limitations per year....

The Petitioner's mother enclosed medical records for her son and a copy of a Michigan statute, Public Act 100 of 2012 (MCL 500.3406s).

1. The claim numbers are: 20150651609200, 20150680214900, 20150680215200, 20150680215100, 20150680236400, 20150680236500, 20150680236800, 20150680214800, 20150680215000, 20150680237300, 20150680214700, 20150680236900.

2. Medical procedures performed by physicians and other health care providers are classified with each procedure given a five-digit code number. This system was established by the American Medical Association which publishes *Current Procedural Terminology*, a manual used in the health insurance industry for processing insurance claims. The codes, commonly referred to as "CPT codes," are typically five digit numbers that identify a particular medical procedure.

BCBSM's Argument

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

First, I want to address your reference to [Act 100 of 2012]. The [statute is] specific to the treatment of Autism Spectrum Disorder. Consistent with the bills, BCBSM pays for the treatment of Autism. As indicated on Page 21 of the *Blue Cross Premier Gold Benefits Certificate*...your coverage provides for the diagnosis and outpatient treatment of Autism Spectrum Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

The Autism benefit provides coverage for diagnostic services, treatment, applied behavioral analysis treatment, psychiatric care, and psychological care (Pages 21-22). Therapeutic care is a component of applied behavior analysis and includes occupational therapy. Therapeutic care is described on Page 22 as follows:

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

The autism benefit limits occupational therapy on Page 23 of the certificate as follows:

Limitations and Exclusions:

- 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.

* * *

In this case, the services provided were *Therapeutic Exercises* (Procedure 97110) and/or *Therapeutic Activities* (Procedure Code 97530) with a diagnosis of *Unspecified Disorders of the Nervous System* (Diagnosis Code 349.9) or Pervasive Developmental Disorders, Autistic Disorder (Diagnosis Code 299.0)...

I have reviewed each claim eligible for appeal and confirmed the claims are processing correctly. There is a 30-visit combined outpatient maximum for all physical therapy, occupational therapy, chiropractic spinal manipulation and mechanical traction, and osteopathic manipulative therapy. Because the 2014 benefit maximum is met, you are responsible for non-covered charges in the amount of \$1,155.00.

* * *

I understand that you are requesting that BCBSM pay all occupational services provided to your son in 2014 based on his Autism diagnosis; however, we did not receive claims for ABA treatment/therapy. Applied Behavior Analysis is a different type of treatment/benefit than physical, occupational, and/or speech/language pathology benefits and should not be used interchangeably. In addition, Applied Behavior Analysis treatment must be approved for payment through BCBSM's prior authorization process (Page 21). If prior authorization is not obtained, rendered services will not be covered and the member will be responsible to pay for those services. Prior authorization is not required for other covered autism services.

Director's Review

The claims under review in this order are for therapy to treat the Petitioner's autism. BCBSM does not dispute this fact. The treatment of autism is a benefit required by MCL 500.3406s, which provides:

(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.

In denying coverage, BCBSM cited a clause in its *Premier Gold Benefits Certificate* which states on page 23:

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.

The limitation for these services is 30 per calendar year. See page 68 of the *Premier Gold Benefits Certificate*. This limitation, when imposed in the treatment of autism, is inconsistent with the mandate of MCL 500.3406s.

In addition, in an email submitted for this review, BCBSM alleges that the Petitioner did not submit a required autism evaluation and diagnosis until June 18, 2015. BCBSM has not identified the source of such a requirement, nor did BCBSM raise this issue in its final adverse determination. MCL 500.3406s does not require the submission of such a document as a

prerequisite to receiving autism treatment. The *Premier Gold Benefits Certificate*, page 21, requires an autism evaluation and diagnosis but only when applied behavioral analysis (a form of autism treatment) is requested. BCBSM states in its final adverse determination that applied behavioral analysis is not a part of the autism treatment at issue in the Petitioner's appeal. The evaluation and diagnosis requirement in the certificate does not apply to the therapy the Petitioner received and is therefore not a legitimate reason to deny coverage.

The Director finds BCBSM's decision to deny coverage for the Petitioner's therapy is not in compliance with the terms and conditions of the *Premier Gold Benefits Certificate* and is prohibited by the Michigan Insurance Code.

V. ORDER

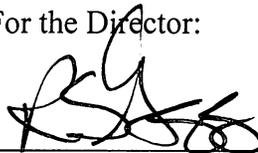
The Director reverses BCBSM's September 16, 2015 final adverse determination. BCBSM shall immediately provide coverage for the twelve claims from Building Bridges Therapy, subject to any applicable copayment or deductible requirements. See MCL 550.1911(17). BCBSM shall, within seven days of providing coverage, provide 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 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