

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. 152586-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 15th day of April 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 23, 2016, ██████████ (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.*

The Petitioner receives health care benefits through an individual plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The benefits are described in BCBSM's *Premier Silver Benefits Certificate*. The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. BCBSM responded on March 30, 2016, and on that date the Director accepted the Petitioner's request.

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 September 23, 2015, the Petitioner had surgery on her right shoulder and began physical therapy. In November 2015 she developed a frozen shoulder. Mid-Michigan Physical Therapy requested BCBSM provide authorization for additional therapy. Between November 10, 2015 and December 31, 2015 the Petitioner received 22 additional therapy sessions at Mid-Michigan Physical Therapy. BCBSM denied coverage for the visits asserting that the Petitioner

had already received the maximum number of physical therapy sessions for the 2015 calendar year.

The Petitioner appealed BCBSM's denial through its internal grievance process. At the conclusion of that process, on February 22, 2016, BCBSM issued its final adverse determination affirming its denial of coverage. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Is BCBSM required to provide coverage for the Petitioner's physical therapy visits between November 10, 2015 and December 31, 2015?

IV. ANALYSIS

BCBSM's Argument

In its February 22, 2016 final adverse determination, BCBSM's representative wrote:

This letter is in response to your appeal regarding denial of payment for physical therapy services on November 10, 13, 16, 18, 20, 23, 25, 27, and 30, 2015, and December 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 28, 29, and 31, 2015....After review, I must maintain denial of payment for these services; we have already paid the maximum benefit available for physical therapy visits under your contract. Under your coverage, BCBSM pays for a maximum of 30 combined outpatient visits for physical therapy, occupational therapy, chiropractic manipulations, and osteopathic manipulative therapy. Because you had already met your maximum allowed visits, you remain liable for the non-covered charges.

* * *

On June 29, 2015, you reached the maximum visits allowed under your contract, and any occupational therapy, physical therapy, chiropractic manipulations, and osteopathic manipulative therapy services rendered after this date are not covered until the following calendar year.

I understand your concern that the provider's representative provided information to you that you had 30 visits remaining, and that is why you scheduled the physical therapy visits. However, we have no record of any telephone calls made by the provider's office prior to the dates of service in question.

Petitioner's Argument

In her external review request, the Petitioner wrote:

I'm hoping you can provide assistance with a claim issue I am having with BCBSM for my above mentioned physical therapy services. My provider, Mid-Michigan Physical Therapy and Rehab Specialists called BCBSM on 11/6/2015

and spoke with [REDACTED], who advised I had 30 Physical Therapy office visits available as of that date. Mid-Michigan Physical Therapy and Rehab also verified on 11/6/2015 through the BCBSM provider on-line verification of services that I had 30 Physical Therapy visits remaining....

BCBSM is now denying my services, stating I did not have any Physical Therapy services available to me at that time, even though my provider called BCBSM on 11/6/15 to confirm benefits (spoke with [REDACTED]) and on 11/6/15 checked the BCBSM on-line benefits verification which also showed I had 30 physical therapy visits available to me.

I submitted a written appeal regarding the denial of these service to BCBSM on January 13, 2016, and received a written denial from BCBSM dated February 22, 2016, stating my provider never called BCBSM to have these services approved and that I had already used the maximum visits available prior to 11/6/2015. This is completely untrue as we have attached verification showing my provider spoke with Latoyka on 11/6/2015, and she approved 30 physical therapy visits for 2015.

Based on the information BCBSM confirmed with my provider, by phone and their on-line verification of benefits on 11/6/2015, I feel BCBSM should be held responsible and these services should be processed and paid.

Director's Review

The *Premier Silver Benefits Certificate* (page 69) provides:

We pay for...a maximum of 30 outpatient visits per member per year....

This 30 visit maximum renew each calendar year. It includes all in-network and out-of-network outpatient visits, regardless of location, for:

- Occupational therapy
- Physical therapy (includes physical therapy by a chiropractor)
- All chiropractic manipulations
- Osteopathic manipulative therapy

On page 71 the *Certificate* further states:

We do not pay for:

More than 30 outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider.

The Petitioner argues that the additional physical therapy visits should be covered because a BCBSM representative gave inaccurate information to her provider's office indicating she had 30 visits remaining as of November 6, 2015. BCBSM states that it has no record of receiving a call from the provider's office prior to the dates of service in question.

In a review under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether BCBSM properly administered its members' benefit plans. The

Director has no authority to amend the terms of a benefit plan to require BCBSM to provide coverage that is inconsistent with the plan.

BCBSM provided coverage for 33 physical therapy visits for the Petitioner between January 5, 2015 and June 8, 2015. Although the Petitioner may have needed more than 30 therapy visits to treat her medical problems, nothing in the certificate or applicable law requires BCBSM to cover more than 30 therapy visits.

The Director finds that BCBSM's denial of coverage for the physical therapy visits the Petitioner received between November 10, 2015 and December 31, 2015 was in accord with the terms of the *Premier Silver Benefits Certificate*.

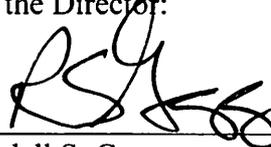
V. ORDER

The Director upholds Blue Cross Blue Shield of Michigan's final adverse determination of February 22, 2016.

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, P.O. Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director