

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. 151097-001-SF

State of Michigan, Plan Sponsor

and

Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

Issued and entered
this 27th day of December 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 1, 2015, ██████████, authorized representative of ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review, appealing a claim denial issued by Blue Cross Blue Shield of Michigan (BCBSM). BCBSM is the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The claim denial concerned the Petitioner's request for coverage for treatment at ██████████.

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 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. The Petitioner's health benefit plan is such a governmental self-funded plan. On December 8, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request for review.

The Director notified BCBSM of the external review request and asked BCBSM to submit the information used to make its final adverse determination. BCBSM provided its response on December 15, 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 27, 2015, the Petitioner was assaulted and suffered a serious head injury. He was taken to a hospital in [REDACTED] and later transferred to [REDACTED]. He was discharged to [REDACTED] Hospital in [REDACTED] on July 9, 2015 for inpatient rehabilitation which was expected to continue for four to six weeks.

Following treatment at [REDACTED] Hospital, the Petitioner was to be transferred to the [REDACTED] facility. [REDACTED] is licensed in Michigan as an Adult Foster Care Facility. It is not licensed as a hospital or skilled nursing care facility. (The Petitioner's authorized representative, [REDACTED] is the executive director of [REDACTED] [REDACTED])

A July 23, 2015 assessment ("plan of care") by the staff of [REDACTED] concluded that the Petitioner would require 90 to 120 days treatment in its "post-acute brain injury transitional program." According to the plan:

[Petitioner] will participate in PT, OT, SLP [physical therapy, occupational therapy, and speech and language pathology services], Counseling, Neuropsychology for 6 hours per day, 5 days per week. Nursing will assist to provide with medication dispensing and education. His treatment plan will include transfer of the goals worked on during the day to the evening and weekends in the real world setting. The program includes intense collaboration and training between all shifts and staff in order to provide the very best outcome possible. It is anticipated [Petitioner] will be medically stable at the time of his discharge from [REDACTED]. At that time he will continue to require intense medical coordination with medical specialties which will be provided.

Before the Petitioner left [REDACTED] Hospital his physician requested coverage from BCBSM for the [REDACTED] treatment. BCBSM denied the request. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM issued its final adverse determination on September 28, 2015, affirming its denial. In its final adverse determination issued to the Petitioner's wife, BCBSM wrote:

Your husband is covered under the *Community Blue Group Benefits Certificate for Administrative Service Contracts (ASC)*. **Section 4: How Providers are Paid** (Page 110) of the *Certificate* explains that BCBSM will not pay for services received at nonparticipating hospitals, facilities, or alternatives to hospital care. As Hope Network Neuro Rehabilitation is a nonparticipating provider, preauthorization for services cannot be approved. Therefore, you will be liable for the charges if care is received at this provider.

The Petitioner's representative argues that BCBSM is required to provide coverage for the [REDACTED] treatment under the terms of BCBSM's *Your Benefit Guide State Health Plan PPO for Non-Medicare retirees* and BCBSM's *Community Blue Group Benefits Certificate*. The Petitioner's representative argues that coverage must be provided both as a matter of contract interpretation and because the treatment is medically necessary. The

representative asserts that BCBSM has failed to provide the required medical necessity review.

III. ISSUES

This case presents three issues which the Director must address in order to resolve the Petitioner's appeal:

1. What documents define the Petitioner's coverage?
2. What is the status of the [REDACTED] facility (participating or nonparticipating, in-network or out-of-network)?
3. Is BCBSM required to provide coverage for the Petitioner to be treated at the [REDACTED] facility?

This review does not require the Director to determine whether the proposed treatment is medically necessary. The Petitioner's physicians have concluded the treatment is medically necessary. The Director accepts, for purposes of this review, that the treatment is medically necessary. However, benefit plan sponsors are not required to provide coverage for all medically necessary treatment. Coverage is determined by the terms of the relevant certificate of coverage and any applicable statute.

IV. DIRECTOR'S REVIEW

Coverage documents

The Petitioner's representative cited two BCBSM coverage documents in support of the claim that the Hope Network treatment should be covered:

- The *Benefit Guide to the State Health Plan PPO for Non-Medicare retirees*
- The *Community Blue Group Benefits Certificate*

The Petitioner is a State of Michigan retiree not yet eligible for Medicare. There are two documents which define the benefits for such individuals: the *Benefit Guide to the State Health Plan PPO for Non-Medicare retirees* and the *Community Blue Group Benefits Certificate for Administrative Service Contracts (ASC)*.

The *Community Blue* certificate cited by the Petitioner's representative, is BCBSM's *Community Blue Group Benefits Certificate*. This document is a certificate of coverage which BCBSM uses for underwritten benefit plans and is not to be confused with BCBSM's *Community Blue Group Benefits Certificate ASC* which is used for self-funded benefit plans. The Petitioner's State of Michigan benefit plan is self-funded. For that reason, the *Community Blue Group Benefits Certificate* forms no part of his coverage.

In its final adverse determination, BCBSM cited one provision in the *Community Blue Group Benefits Certificate ASC* certificate of coverage. BCBSM did not reference the *Benefit Guide*.

Both the *Community Blue ASC* and the *Benefit Guide* list the medical services which are covered. The *Community Blue ASC* certificate lists 44 covered services (pages 18-109); the *Benefit Guide* lists 57 covered services (pages 5-32). Both documents include among the covered services: physical therapy, occupational therapy, speech therapy, and skilled nursing care. Both documents also include lists of medical services for which no coverage is provided. Those provisions are excerpted below:

The *Community Blue ASC* certificate, on page 121, provides:

Alternative facility services that we do not pay for:

We do not pay for any facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

On page 53, the *Community Blue ASC* certificate states:

Locations: We pay for facility and professional occupational therapy services in the following locations subject to the conditions described below:

- A participating hospital, inpatient or outpatient
- Inpatient therapy must be used to treat the condition for which the member is hospitalized.
- A participating freestanding outpatient physical therapy facility
- An office of a physician or an independent occupational therapist
- A participating skilled nursing facility
- The patient's home (see Page 121 for when services may be payable in a nursing home)

Regarding physical therapy, the *Community Blue ASC* certificate, on page 67, states:

Physical therapy must be...[g]iven by the approved providers in the locations listed below:

- A hospital, inpatient or outpatient
- A skilled nursing facility
- A freestanding outpatient physical therapy facility
- A provider's office
- A member's home
- A nursing home if it is the member's primary residence

The *Benefit Guide*, on page 26, states:

Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other facility independent of a hospital or an independent sports medicine facility.

provider status

BCBSM categorizes its providers according the following classifications: participating or nonparticipating and in-network or out-of-network. These terms are defined in the glossary of the *Community Blue ASC* certificate. Participating providers have signed agreements with BCBSM to accept BCBSM's approved amounts as payment in full for their services. Nonparticipating providers have no such agreements. The [REDACTED] has not signed such an agreement with BCBSM.

In-network providers are hospitals, physicians and other licensed facilities or health care professionals who provide services through BCBSM's preferred provider organization (PPO) program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under the PPO program. The [REDACTED] is not an in-network provider.

coverage

Based on the information provided in the Petitioner's appeal, it appears that the requested medical services are to be provided by the staff of the [REDACTED] facility. None of these individuals have been identified as BCBSM participating providers. The [REDACTED] facility itself is not a participating provider. In addition, the [REDACTED] facility is clearly not the Petitioner's primary residence. Given these facts, the Director finds that the requested medical services, although they may be medically necessary, are not covered benefits.

V. ORDER

The Director upholds Blue Cross Blue Shield of Michigan's final adverse determination of September 28, 2105.

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