

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. 153357-001-SF

**University of Michigan University, Plan Sponsor
and
BCN Service Company, Benefit Administrator
Respondents**

**Issued and entered
this 25th day of May 2016
by Randall S. Gregg
Special Deputy Director**

ORDER

I. PROCEDURAL BACKGROUND

On April 22, 2016, ██████████ (Petitioner), filed a request for external review with the Department of Insurance and Financial Services. The request for review concerns a denial of coverage issued by BCN Service Company (BCNSC) for treatment of an eating disorder. BCNSC is the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The benefits are described in BCNSC's *U-M Premier Care Benefit Document*.

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.

The Director notified BCNSC of the appeal and asked it to provide the information used to make its final adverse determination. BCNSC furnished its response on April 28, 2016. On April 29, 2016, after a preliminary review of the information submitted, the Director accepted the request for review. BCNSC submitted additional material on May 4, 2016.

This case involved a medical issue so the Director assigned it to an independent review organization which provided its analysis and recommendation to the Director on May 11, 2016.

II. FACTUAL BACKGROUND

The Petitioner is 23 years old and has been diagnosed with bulimia nervosa. She sought care at Insight Behavioral Health Centers (IBHC) of Chicago, Illinois, a center specializing in the treatment of eating disorders. After an initial assessment, IBHC determined that the Petitioner met the criteria for admission to its partial hospitalization program, which requires eight hours of treatment per day, seven days a week. The Petitioner, a full time graduate student, did not want to enter into the partial hospitalization program. Instead, on October 1, 2015, she enrolled in IBHC's intensive outpatient program (IOP) which includes three to five group session per week, one individual therapy session per week, and a weekly meeting with a dietician.

On October 9, 2015, BCNSC received a request for coverage for the Petitioner's IOP treatment. BCNSC approved four visits through October 14, 2015, with a review date of October 16, 2015, to determine continuation in the program. On October 16, 2015, IBHC submitted another authorization request for four visits per week for three weeks, for a total of 12 visits. BCNSC denied the request.

The Petitioner continued IOP treatment through December 9, 2015. BCNSC denied coverage beyond October 14, 2015. The Petitioner appealed the denial through BCNSC's internal grievance process. At the conclusion of that process, on February 11, 2016, BCNSC issued a final adverse determination affirming its denial. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Did BCNSC correctly deny coverage for the Petitioner's treatment in IBHC's intensive outpatient program for the period October 15, 2015 through December 9, 2015?

IV. ANALYSIS

BCNSC's Argument

In its final adverse determination, BCNSC stated the reason for its denial:

The member's condition did not meet the Blue Care Network Behavioral Health Utilization Criteria for continued intensive outpatient care beyond the 4 approved days from 10/9/2015 to 10/14/2015. Sustained improvement in a less restrictive environment was more likely, as per the medical documentation submitted there were no safety issues for continued managed care in an outpatient setting treatment level.

Petitioner's Argument

On her request for external review form the Petitioner stated that she felt that BCNSC's criteria for outpatient treatment "does not match typical clinical practice."

The Petitioner also submitted a letter from IBHC's clinical manager who stated the reasons why coverage should be provided for the Petitioner's continued treatment:

I am writing this letter on behalf of my patient [the Petitioner] ... to advocate for insurance authorization for the treatment she has been receiving at Insight Behavioral Health Center for her Eating Disorder since 10/1/2015.

[Petitioner] was admitted to our program following an assessment with our intake department where she was diagnosed with Bulimia Nervosa....

[Petitioner] presented to us with purging 3-5 sessions/week (purging multiple times in one session "until my stomach is empty") and heavy restriction (consuming less than 30% of what her body needs according to a meal plan decided on by our dietitian....). [Petitioner] was having fruit for breakfast, salad for lunch, and carrots and hummus for dinner. In addition to restriction and purging, [Petitioner] was engaging in daily calorie counting, taking measurements of her body multiple times per day, and weighing herself multiple times per day – including after purging episodes. This was very time consuming and made it difficult for [Petitioner] to focus on completing graduate school and her internship job. [Petitioner's] medical stability was at risk due to the presence of blood in her vomit as well as due to losing an extreme amount of weight (over 50 pounds) in a short period of time before admission.

The Doctor I spoke with on the peer-review call said that he was denying coverage because he did not believe that [Petitioner] would make progress without medication. Since being in our program, [Petitioner] has made tremendous progress without the use of any psychiatric medication. She has increased her daily caloric intake from 30% to 75% as evidenced by her upward weight trend since starting with us. [Petitioner] has also decreased her purging frequency from 3-5 times/week to 1 time every 2-3 weeks. [Petitioner] has also increased her ability to tolerate feelings of fullness. [Petitioner] has engaged in many food-challenge exposures on her own and has greatly increased the variety of foods that she consumes. The blood in her vomit has resolved and she is now only weighing herself 1/day. [Petitioner] has been very committed to the program in terms of following recommendations....It is my professional opinion that [Petitioner] would not have made this progress without this level of care because previously at the outpatient level she was not able to achieve symptom reduction. Our ultimate goal is to help [Petitioner] fully eliminate purging and reach 100% meal plan compliance so that her weight can stabilize and her eating disorder cognitions can subside.

Director's Review

BCNSC's *U-M Premier Care Benefit Document*, in section 8.14, provides coverage for mental health care so long as it is provided in an approved facility or by a participating provider

and is preauthorized as medically necessary. Covered mental health care includes intensive outpatient mental health services. The criteria for mental health services are listed in the Blue Care Network *Utilization Management Criteria for Adult, Adolescent, & Child Mental Health And Substance Abuse Services*. The criteria at issue in the Petitioner's appeal are on page 27:

Each of the following criteria is met:

* * *

2. The member is experiencing functional impairment as a direct result of their eating disorder such that one or more of the following criteria are met:
 - a) The member's condition represents a significant risk to their ability to continue living in their current environment without the support of the proposed treatment;
 - b) The member's condition represents a significant risk to their daily functioning, continued employment or participation at school;
 - c) The member's condition represents a significantly increasing risk to the safety of the member; others or property and the proposed treatment can be reasonable expected to sufficiently mitigate the risk.

The question of whether it was medically necessary for the Petitioner to have been treated at an intensive outpatient level of care between October 15, 2015 through December 9, 2015, was presented to an independent review organization (IRO) for analysis and a recommendation as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO physician reviewer is board certified in psychiatry, has been in active practice for more than 15 years, and is familiar with the medical management of patients with the Petitioner's condition. The IRO report included the following analysis and recommendation:

The member was evaluated for treatment and was found to meet the criteria for a partial hospitalization program, which required 8 hours of treatment per day 7 days per week, but did not want to enter this program and was recommended for intensive outpatient treatment, which included 3 to 5 group sessions per week, 1 individual session per week and weekly meetings with a dietician. The member had been purging 3 to 5 sessions per week and had dietary restrictions. The member had lost approximately 50 pounds in a short period of time, but had increased caloric intake throughout the program from 30 to 75%, as evidenced by a 5.5 pound weight gain. The Health Plan denied coverage based on medical necessity and stated that the member could be treated in a less restrictive environment.

[T]he member was experiencing functional impairment due to her eating disorder. However...based on the information provided for review, it did not appear that the member was at significant risk to not be able to continue living in her current environment...[T]he member could have been treated in a lesser restrictive setting during the period at issue in this appeal.

Pursuant to the information set forth above and available documentation...it was not medically necessary for the member to have been treated at an intensive

outpatient level of care from 10/9/15 to 12/09/15. (American Psychiatric Association Practice Guidelines for Eating Disorders. 2006 May.)

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's review is based on extensive experience, expertise, and professional judgment. In addition, the IRO's recommendation is not contrary to any provision of the BCNSC *Benefit Document*. MCL 550.1911(15).

The Director, discerning no reason why the IRO's recommendation should be rejected in the present case, finds that it was not medically necessary for the Petitioner to have been treated in an intensive outpatient program from October 15, 2015 through December 9, 2015. For that reason, the services she received on those dates are not covered benefits.

V. ORDER

The Director upholds BCNSC's final adverse determination dated February 11, 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, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director



Randall S. Gregg
Special Deputy Director