

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 101134-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 19th day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 31, 2008, XXXX, authorized representative of XXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the material submitted and accepted the request on November 13, 2008.

Because it involved medical issues, the Commissioner assigned the case to an independent review organization which provided its analysis and recommendations to the Commissioner on November 26, 2008.

II
FACTUAL BACKGROUND

The Petitioner receives health care benefits from Blue Cross Blue Shield of Michigan (BCBSM) under its *Community Blue Group Benefits Certificate* (the certificate).

The Petitioner received inpatient substance abuse treatment at XXXXX Center (XXXXX) in Minnesota from July 24, 2007, until August 21, 2007. BCBSM denied coverage for this treatment.

The Petitioner appealed the denial through BCBSM's internal grievance process. After a managerial-level conference on July 2, 2008, BCBSM did not change its decision and issued a final adverse determination dated August 28, 2008.

III ISSUE

Did BCBSM properly deny coverage for the Petitioner's treatment at XXXXX from July 24, 2007, until August 21, 2007?

IV ANALYSIS

Petitioner's Argument

The Petitioner says that under her BCBSM certificate, 50% of the cost of substance abuse treatment is covered (after the deductible is met) whether in network or out of network, with a \$15,000 per year maximum and a lifetime maximum of \$30,000. Under these terms, the Petitioner believes BCBSM should reimburse her \$12,108.69 (50% of XXXXX's charge of \$24,217.38).

BCBSM denied coverage for the Petitioner's stay at XXXXX saying the treatment was "not medically necessary." The Petitioner believes this is contrary to the circumstances of her illness and was not based upon the established BCBSM criteria for "Residential Treatment, Substance-Related Disorder, Adult." The Petitioner says that BCBSM's decision was also contrary to the opinion of her examining psychiatrist and her current addiction counselor.

The Petitioner says that she has a well-documented substance abuse problem. After a number of failed outpatient treatment efforts, the Petitioner was admitted, as an inpatient, to XXXXX Hospital on July 24, 2002, for opiate dependency and benzodiazepine dependence. She was released ten days later. At that time BCBSM determined that inpatient care was medically necessary and a covered benefit.

In the fall of 2006 the Petitioner started using drugs again. Over time her condition worsened but she denied she had a problem and failed to seek treatment. By July 2007 her

condition was such that she decided to seek treatment in another facility. After doing some research and making innumerable phone calls, she chose to seek treatment at XXXXX, which had a bed available immediately. She arrived at XXXXX on July 24, 2007.

The Petitioner believes that her inpatient care at XXXXX was medically necessary. She argues that she meets all the criteria established by BCBSM, and therefore her treatment is a covered benefit. She wants BCBSM to cover this care under the terms of her certificate.

BCBSM's Argument

BCBSM says that under the terms of the certificate, services must be medically necessary to be covered. BCBSM has established, through Magellan, its behavioral health manager, medical necessity criteria for residential treatment of adult substance abuse disorders. BCBSM's medical consultants reviewed the documentation and decided that the Petitioner's care at XXXXX was not medically necessary. Therefore, BCBSM concluded it was not a covered benefit.

Commissioner's Review

The Petitioner's certificate sets forth the benefits that are covered. In *Section 3: Coverage for Hospital, Facility and Alternatives to Hospital Care*, the certificate states (page 3.2):

- For covered services to be payable, they must be medically necessary....

Also, the definition of the term "medically necessary" in *Section 7: The Language of Health Care* page 7.13) says: "A service must be medically necessary in order to be covered."

The question of whether the Petitioner's residential substance abuse care at XXXXX was medically necessary was presented to an IRO for analysis as required by section 11(6) of the Patient's Right to Independent Review Act. The IRO physician reviewer is board certified in addiction psychiatry, and has been in active practice for more than ten years.

The IRO report said in part:

The MAXIMUS physician consultant indicated that the admission review check list sheet reported that withdrawal symptoms were not expected, the [Petitioner] was not in imminent danger of serious physical damage to her

physical health and that medical monitoring was not needed for a medical condition. The MAXIMUS physician consultant also indicated that the physician's examination report dated 7/25/07 provides no objective reasoning for the need for 24 hour medical or nursing monitoring for the [Petitioner]. The MAXIMUS physician consultant explained that no unstable vital signs were noted. The MAXIMUS physician consultant also explained that there were no signs or symptoms of intoxication or withdrawal noted in the records. The MAXIMUS physician consultant indicated there was no evidence in the records from this admission that the [Petitioner] was experiencing severe withdrawal or that severe withdrawal was imminent, that there was a serious risk to her physical health, that she required 24 hour nursing and medical monitoring, or that she had an unstable behavioral health condition that required 24 hour medical monitoring or violent behavior posing imminent danger. The MAXIMUS physician consultant also indicated that the [Petitioner] could have been appropriately treated at a lower level of care during the period at issue in this appeal.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it was not medically necessary for the [Petitioner] to have been treated at a residential level of care from 7/24/07 to 8/21/07.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner accepts the recommendation of the IRO and finds that the Petitioner's substance abuse care at XXXXX was not medically necessary for treatment of her condition and therefore is not a covered benefit under the certificate.

V ORDER

Respondent BCBSM's August 28, 2008, final adverse determination is upheld. BCBSM is not required to cover the Petitioner's care at XXXXX from July 24, 2007 until August 21, 2007.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later

than sixty days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.