

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. 104420-001

v

Trustmark Life Insurance Company
Respondent

Issued and entered
this 15th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 23, 2009, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on April 28, 2009.

The Commissioner notified Trustmark Life Insurance Company (Trustmark) of the external review and requested the information used in making its adverse determination. Information was received on April 28 and May 13, 2009.

The case involves medical issues so the Commissioner assigned it to an independent review organization which provided its recommendation to the Commissioner on May 20, 2009.

II
FACTUAL BACKGROUND

The Petitioner, born XXXXX, has health care benefits as an eligible dependent under group coverage underwritten by Trustmark. Her benefits are defined in the master policy.

The Petitioner received inpatient (residential) rehabilitation for alcohol and substance abuse at the XXXX (XXXXX) in XXXXX from August 7, 2008, until she was discharged on September 3, 2008 (28 days). Trustmark covered the first 15 days of care but denied coverage for the period August 23 to September 3 saying it was not medically necessary. The Petitioner appealed Trustmark's denial.

After the Petitioner completed Trustmark's internal grievance process, Trustmark maintained its denial and issued a final adverse determination dated March 10, 2009. The Petitioner now seeks review under PRIRA.

III ISSUE

Was Trustmark correct in denying coverage for the Petitioner's care from August 23 to September 3, 2008?

IV ANALYSIS

Petitioner's Argument

Before the Petitioner was admitted to XXXXX, her treating psychologist and evaluating psychiatrist both recommended inpatient treatment as medically necessary. Her family paid in advance for 28 days of treatment (\$25,688.95) at XXXXX. After the Petitioner was discharged and the claims for the treatment were submitted, Trustmark only reimbursed the Petitioner for \$14,779.50, saying not all her care was medically necessary.

The Petitioner argues that Trustmark's care management should have done a better job with her case and informed her before the end of her stay at XXXXX that it did not think all her inpatient care was medically necessary. The Petitioner's authorized representative said, "[H]ad Trustmark's case management continued to be involved, I would have been alerted that they did not feel inpatient care was medically necessary after August 22, 2008 and could have made arrangements at that time. By handing down the denial two months after the services were incurred, I am left with

\$10,909.45 of unreimbursed services.”

The Petitioner wants Trustmark’s determination reviewed.

Respondent’s Argument

Trustmark initially precertified the Petitioner’s stay at XXXXX for seven days, then precertified an additional eight days. At the end of that period, Trustmark determined that inpatient care was no longer medically necessary. The policy excludes treatment, services or supplies which are not medically necessary. “Medically Necessary (Medical Necessity)” is defined (page 36) as:

A service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

In its final adverse determination, Trustmark told the Petitioner:

We have received your grievance...and we understand that you are concerned about the partial denial of services as only part of the inpatient stay was precertified.

The information submitted has been reviewed by an outside consultant who has upheld the original determination. The inpatient stay from 08/23/08 – 09/03/08 was not medically appropriate. During the time period in question, there was no indication of withdrawal symptoms. The [Petitioner] did not show behavioral symptoms that required monitoring or containment on a 24/7 basis. [Petitioner] did make a suicidal statement just prior to discharge but there is no additional indication of serious risk to self or others. The data reviewed in sum does not establish that the [Petitioner] could not have been safely and effectively treated in less restricted setting as of 08/23/08. Medical necessity for residential services therefore are not established for the time period 08/23/08 – 09/03/08 and the documentation does not support the [Petitioner’s] stay beyond 08/23/08.

Trustmark believes it correctly processed the Petitioner’s claims for care at XXXXX.

Commissioner’s Review

The issue here is whether the Petitioner required treatment for her alcohol and substance abuse problems at the inpatient level from August 23 to September 3, 2008. Under PRIRA, the Commissioner seeks the recommendation of an independent review organization (IRO) whenever

an adverse determination involves questions of medical necessity or clinical review criteria.

The IRO reviewer in this case is a physician who is board certified in psychiatry and has been in practice for more than 20 years. The IRO reviewer concluded that it was medically necessary for the Petitioner to have been treated at an inpatient residential level of care from August 23 to September 3, 2008. The IRO report said in part:

The MAXIMUS independent physician consultant, who is familiar with the medical management of patients with the [Petitioner's] condition, has examined the medical record and the arguments presented by the parties.

The results of the MAXIMUS physician consultant review indicate that this case involves a xx year-old female who has a history of substance abuse. At issue in this appeal is whether it was medically necessary for the [Petitioner] to have been treated at an inpatient residential level of care from 8/23/08 to 9/3/08.

The MAXIMUS physician consultant noted that the [Petitioner] has an eight year history of polysubstance abuse. The MAXIMUS physician consultant also noted that a diagnosis of bipolar disorder has been considered for her. The MAXIMUS physician consultant indicated that the [Petitioner] suffered from marked generalized anxiety and low self-esteem. The MAXIMUS physician consultant also indicated that the [Petitioner] demonstrated some resistance to treatment. The MAXIMUS physician consultant further indicated that the [Petitioner] was admitted for residential treatment on 8/7/08.

The MAXIMUS physician consultant explained that the [Petitioner] exhibited continued poor impulse control during the period at issue in this appeal. The MAXIMUS physician consultant also explained that the [Petitioner] failed to benefit from several months of outpatient care, including dialectical behavioral therapy and biofeedback, prior to admission. The MAXIMUS physician consultant indicated that the [Petitioner] remained at high risk for relapse during the period at issue in this appeal. The MAXIMUS physician consultant also indicated that the [Petitioner] required the structure and supervision of a residential level of care due to her high risk of relapse, impulsive behavior and resistance to treatment.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it was medically necessary for the [Petitioner] to have been treated at an inpatient residential level of care from 8/23/08 to 9/3/08.

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’s analysis is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the recommendation of the IRO and finds that the Petitioner’s inpatient care at issue in this case was medically necessary.

V
ORDER

Trustmark’s March 10, 2009, final adverse determination is reversed. Trustmark shall cover the Petitioner’s inpatient residential treatment from August 23 through September 3, 2008, subject to the terms and conditions of the policy.

Trustmark shall provide coverage within 60 days of the date of this Order and shall, within seven days of providing coverage, provide the Commissioner with proof it has implemented this Order. To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.