

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. 107109-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 14th day of January 2011
by Ken Ross
Commissioner

ORDER

I

PROCEDURAL BACKGROUND

On September 2, 2009, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The initial request was incomplete. After additional information was provided, the Commissioner accepted the request on September 21, 2009.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 30, 2009.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

II

FACTUAL BACKGROUND

The Petitioner receives health care benefits through the State of Michigan Health Plan PPO

for retired state employees. This is a self-funded group administered by BCBSM. Her benefits are defined in the *State Health Plan Benefit Guide* (the benefit guide).

The Petitioner fractured her hip and was admitted to the hospital on January 23, 2009, and was discharged on February 3, 2009. A social worker made arrangements for the Petitioner to receive attendant care from XXXXX Home Care (XXXXX) to take care of her at home. She received 12 hours of care seven days a week for five weeks. The care consisted of cleaning, cooking, errands, paying bills and taking the Petitioner to her doctor's appointments. The amount charged for this care was \$10,500.00. BCBSM denied coverage for the home care services.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on August 6, 2009, and issued a final adverse determination dated August 11, 2009.

III ISSUE

Is BCBSM required to cover the home care services the Petitioner received from XXXXX from February 2, 2009, through March 9, 2009?

IV ANALYSIS

Petitioner's Argument

The Petitioner believes that the home care she received from XXXXX is a covered benefit under her health care plan. She argues that they did not provide housekeeping services, transportation or custodial care. They assisted with activities of daily living, bathing, dressing and meal preparation.

The Petitioner also maintains at least two BCBSM customer service representatives told her that this bill would be paid. She believes that BCBSM is required to pay for this care.

BCBSM's Argument

BCBSM says the Petitioner's benefits are described in the benefit guide on page 44:

Home Health Care Program

Your home health care benefit covers unlimited visits when the service is provided by a participating home health care agency and preauthorized by BCBSM.

Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

The physician must certify that the patient is confined to the home due to illness and that home health care services are being used instead of inpatient hospital care. The physician must also prescribe and submit a detailed treatment plan to the agency. Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Home health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services
These services may include assistance with activities of daily living such as bathing, dressing, meal preparation and feeding.
- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy
- Nursing care by a licensed practical nurse or a licensed vocational nurse when the services of a registered nurse are unavailable

* * *

The State Health Plan PPO does not pay for:

- General housekeeping services
- Cost of meals
- Transportation to or from a hospital or other facility
- Elastic stockings, including nonprescription compression socks
- Sheepskin
- Comfort items such as lotion, mouth wash or body powder
- Physician services
- Custodial or nonskilled care

In the Petitioner's case BCBSM did not preauthorize the home health care services. The services rendered and billed by XXXXX for the Petitioner (housekeeping, transportation, cooking, paying bills and grooming needs) are considered custodial care in nature or non-skilled care. Therefore, BCBSM believes the services were appropriately denied.

BCBSM also argues that it did not mislead the Petitioner. Its records indicate that its customer service department informed the Petitioner that a home health agency would have to be

approved and a treatment plan would have to be submitted to confirm skilled care in the home. BCBSM maintains that the denial of the Petitioner's home health care was appropriate because custodial care is not a payable benefit as stated in the benefit guide.

Commissioner's Review

The language of the benefit guide is clear. For a member to receive covered home health care benefits it must be preauthorized by BCBSM and the patient must be receiving skilled nursing care or physical or speech therapy. The benefit guide also specifically excludes custodial or non-skilled care.

No information was provided in this case that the Petitioner's home health care was preauthorized by BCBSM or that the Petitioner received skilled care. Whatever the exact nature of the care provided, before it would be covered, it was necessary that a detailed treatment plan be submitted to BCBSM and approved before the care began. This did not occur.

Finally, the Petitioner argues that she was led to believe by BCBSM's customer service representatives that her home health care was a covered benefit. BCBSM indicated that its records show that no misleading information was provided to the Petitioner. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract or state law. Resolution of the factual dispute described by the Petitioner cannot be a part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM correctly applied the provisions of Petitioner's benefit guide.

**V
ORDER**

BCBSM's final adverse determination of August 11, 2009, is upheld. BCBSM is not required to cover the Petitioner's home health care provided from February 2, 2009, through March 9, 2009.

This is a final decision of an administrative agency. 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. See MCL 550.1915(1), made applicable by MCL 550.1952(2). 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.

Ken Ross
Commissioner