

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 113580-001-SF

v

Blue Cross Blue Shield of Michigan  
Respondent

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Issued and entered  
this 28th day of April 2011  
by R. Kevin Clinton  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On August 4, 2010 XXXXX, authorized representative of his father 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 Commissioner reviewed the material submitted and accepted the request on August 11, 2010.

The Petitioner receives health care benefits as a retiree of the XXXXX, a self-funded plan administered by Blue Cross Blue Shield of Michigan (BCBSM). The Commissioner notified Blue Cross 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 August 20, 2010.

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 (PRIRA), MCL 550.1901 *et seq.*

To address the medical issues in the case, the Commissioner assigned the case to an

independent medical review organization which provided its analysis and recommendation to the Commissioner on August 30, 2010.

## II FACTUAL BACKGROUND

The terms of the Petitioner's coverage are contained in BCBSM's *Comprehensive Hospital Care Group Benefit Certificate* and *Professional Services Group Benefit Certificate*. *Rider CC* also applies.

From June 13 to July 29, 2010, the Petitioner received care at XXXXX and Nursing (XXXXX). BCBSM denied coverage based on its belief that the care was not skilled care and therefore not a covered benefit.

The Petitioner appealed the denial through BCBSM's internal grievance process but BCBSM did not change its decision. BCBSM issued a final adverse determination dated July 19, 2010.

## III ISSUE

Did BCBSM properly deny coverage for the Petitioner's care at XXXXX from June 13 to July 29, 2010?

## IV ANALYSIS

### Petitioner's Argument

After a bout with pneumonia and a weeklong stay in the hospital, the Petitioner was admitted to XXXXX on April 28, 2010. He was prescribed nursing care for physical therapy, occupational therapy, and speech therapy.

The Petitioner received skilled nursing care until his Medicare coverage for nursing care ended on June 12, 2010. To continue skilled nursing care, he would have had to pay around \$18,000.00 per month out of pocket. He couldn't afford that, so skilled care was interrupted and he began receiving custodial care while waiting for approval from BCBSM to move him to a BCBSM in-network facility.

Sometime after June 14, 2010, XXXXX Home and Hospital for the Aged requested precertification from BCBSM to allow the Petitioner into their facility. The request was denied. The Petitioner's primary care physician sent a letter to BCBSM on June 18, 2010, stating that skilled care was medically necessary. Weeks of futile efforts to get in-network skilled nursing care approved by BCBSM followed. On July 15, the Petitioner received a letter from BCBSM dated July 12, 2010, stating that the request was denied because the primary care physician did not return calls from BCBSM physicians. The Petitioner's son indicated that was not true, although there was "phone tag" on both sides that complicated matters. Eventually, BCBSM denied the request for skilled care since the care he was receiving was not skilled in nature. The Petitioner's son indicated that skilled care was medically necessary and that he had received such care previously.

Eventually, BCBSM approved the skilled care the Petitioner began receiving at XXXXX Home beginning on July 30, 2010. However, the Petitioner also wants BCBSM to cover the care he received at XXXXX from June 12 to July 29, 2010, since it was medically necessary and BCBSM was responsible for the delay in transferring him to XXXXX Jewish Home.

#### BCBSM's Argument

While the Petitioner was at XXXXX, BCBSM received a precertification request from XXXXX Jewish Home on July 2, 2010. BCBSM reviewed the case and determined that Petitioner did not meet BCBSM's criteria for skilled nursing care. The case was then sent to the BCBSM physician consultant who called the Petitioner's physician to discuss the case. The physician did not return BCBSM's calls, and the case was closed on July 7, 2010.

The Petitioner's physician called BCBSM on July 8 and left a voicemail asking for a reconsideration of the denial. The BCBSM physician attempted to call back the doctor but was unable to reach him and the case was again closed.

On July 12, the Petitioner's doctor requested an expedited appeal. According to BCBSM, the Petitioner's doctor confirmed that the Petitioner was not receiving any skilled services. BCBSM says that its physician explained to the Petitioner's doctor that the services could not be approved

for coverage because the services were not skilled nursing care.

When the precertification request was made, there were no medical records available from XXXXX Jewish Home as the patient was attempting to transfer to that participating facility. BCBSM says it explained to the Petitioner's son what information was needed for an evaluation to be made.

On August 20, 2010, BCBSM was able to access and review the Petitioner's medical records from XXXXX Jewish Home. After review of these records BCBSM determined that it appeared the Petitioner was receiving skilled care at XXXXX Jewish Home. Therefore, BCBSM pre-certified and approved the Petitioner's stay at XXXXX Jewish Home from July 30, 2010, when he was admitted, to September 1, 2010.

Because the care the Petitioner received at XXXXX Shores from June 12, 2010, until July 29, 2010, was custodial and not skilled care and because it was not provided at a participating facility the care is not a covered benefit under the certificate.

#### Commissioner's Review

The question of whether the Petitioner's care at XXXXX Shores was custodial or skilled in nature was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the Patient's Right to Independent Review Act. The IRO reviewer is a physician in active practice certified by the American Board of Internal Medicine, a Diplomate in geriatric medicine and internal medicine and is a clinical assistant professor of medicine at a university medical school. The reviewer is a Fellow of the American College of Physicians and is published in peer reviewed medical literature. The physician reviewer determined that medical necessity was not established for skilled nursing care for the Petitioner at XXXXX from June 13, 2010, to July 29, 2010. The IRO report includes the following comments and conclusions.

As of June 13, 2010, the [Petitioner] has multiple chronic, but stable medical issues. He had stable vital signs with no acute medical issues that would warrant skilled nursing intervention. He had no evidence of skin breakdown, remained afebrile, and was clinically at his baseline. He remained with total care needs for transfers, dressing, feeding, toileting, and bathing, and was unable to ambulate. He made no significant progress with therapy, and no longer required the skills of a therapist for his care needs. The [Petitioner's] care at this time became custodial, or maintenance in nature. Skilled level

nursing care was no longer required. According to the physician orders, the [Petitioner] was discharged from the skilled rehab service to residential care for maintenance therapy on June 13, 2010.

The care for [the Petitioner's] condition would be custodial. The [Petitioner] would require daily assistance to meet his care needs including bathing, dressing, grooming, and feeding, but he no longer required skilled level of care.

The [Petitioner] had multiple advanced, chronic medical problems, but did not have any skilled care needs during the dates of service at issue to warrant continued skilled level of care. His vital signs remained stable, with no evidence of skin breakdown, or signs or symptoms of infection, and no significant change in his level of functioning.

Recommendation:

It is the recommendation of this reviewer that the denial of coverage issued by Blue Cross Blue Shield of Michigan for skilled nursing level of care rendered at XXXXX Nursing and Rehabilitation Center from June 13, 2010 forward be upheld.

While the Commissioner is not required in all instances to accept the IRO's recommendation, it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principle 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 that judgment should be rejected in the present case.

The Petitioner's care at XXXXX from June 13 to July 29, 2010, was custodial in nature and therefore not a covered benefit.

The Petitioner wants BCBSM to cover his custodial care because BCBSM caused the delay in approving his care at XXXXX. BCBSM indicates that it did not cause the delay. 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. The Petitioner's BCBSM health plan includes coverage for skilled nursing care (with certain restrictions) but not "custodial care or rest therapy" (Certificate, page 2.26). In addition, "BCBSM coverage at nonparticipating hospitals, both in and out of Michigan, is limited to services needed to treat an

accidental emergency or accidental injury" (Certificate, page 2.45).

The Commissioner finds that BCBSM correctly applied the provisions of the Petitioner's certificate of coverage.

**V**  
**ORDER**

BCBSM's final adverse determination is upheld. BCBSM is not required to provide coverage for the Petitioner's care at XXXXX from June 13 to July 30, 2010.

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.

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R. Kevin Clinton  
Commissioner