

**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**

**v**

**File No. 121624-001**

**Blue Cross Blue Shield of Michigan**

**Respondent**

---

**Issued and entered**  
**this 1st day of June 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On May 27, 2011, XXXXX (Petitioner) filed a request for expedited 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.* In order to receive an expedited external review under PRIRA, a physician must substantiate that the Petitioner's life or health would be seriously jeopardized, or the Petitioner's ability to regain maximum function would be jeopardized, if an expedited review is not granted. This certification was provided by Petitioner's physician, Dr. XXXXX.

Blue Cross Blue Shield of Michigan (BCBSM) completed its internal expedited review on May 27, 2011. The Commissioner accepted Petitioner's appeal as an expedited review. The matter was assigned to an independent medical review organization which submitted its analysis and recommendation on May 29, 2011.

**II. FACTUAL BACKGROUND**

The Petitioner receives health care benefits under BCBSM's *Community Blue Group Benefits Certificate*. She is 48 years old and has a medical history of pyoderma gangrenosum of the lower extremities, diabetes, hypertension, gallbladder diverticulum, and obesity. On May 10,

2011, she was admitted to a skilled nursing facility, XXXXX of XXXXX. She was approved for treatment there until May 23. Petitioner requested coverage for additional skilled nursing treatment. BCBSM denied additional coverage, ruling that Petitioner did not meet the criteria for continued treatment in a skilled nursing facility.

The Petitioner appealed the denial through BCBSM's expedited grievance process.

### **III. ISSUE**

Did BCBSM properly deny Petitioner's request for additional skilled nursing facility care?

### **IV. ANALYSIS**

#### Petitioner's Argument

Petitioner's request for external review states:

Resident has pyoderma gangrenosum with venous hypertension to bilateral lower extremities with lesions to the entire gaiter distribution.

In a letter dated May 27, 2011, Petitioner's physician wrote:

I am writing in reference to XXXXX, my patient. She has been under my care at XXXXX of XXXXX since May 10, 2011. It is my opinion that she is not medically fit to return home at this time, if sent home at this time it would be life threatening due to her diagnosis and physical condition....The patient is non-ambulatory and is only able to bear weight for a few minutes. It is my opinion that she should be under skilled nursing at XXXXX due to the extent of her wounds and required skilled nursing care.

#### BCBSM's Argument

BCBSM denied coverage for additional days of skilled nursing care because the Petitioner "no longer meets the criteria for a skilled nursing setting." In support of its decision, BCBSM cited the following provision from page 3.46 of the *Community Blue* certificate of coverage:

We pay only for the period that is necessary for the proper care and treatment of the patient up to a maximum of 120 days per member, per calendar year.

### Commissioner's Review

The question of the Petitioner's continued eligibility for skilled nursing care was submitted to an independent medical reviewer (IRO) for analysis as required by section 11(6) of the PRIRA, MCL 550.1911(6). The medical reviewer is a practicing physician, board certified in physical medicine. The reviewer holds an academic appointment and has been in practice for more than 15 years. The reviewer is familiar with the medical management of patients with the Petitioner's condition. The reviewer's report includes the following analysis:

[I]n order for treatment at a skilled nursing facility level of care to be medically necessary, a patient must require skilled nursing and/or skilled rehabilitation and the required daily skilled services must be ones that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis....[I]n order for skilled nursing facility services to be medically necessary, there must be an expectation for practical improvement with realistic goals....[T]he member's active medical issues for her skilled nursing facility admission were her lower extremity dressings for her pyoderma gangrenosum ulcers....[T]he member's ulcers are no longer requiring skilled dressing changes or skilled oversight....[P]ain is an expected consequence of this member's disease....[T]he member's pain was to be managed with oral medications, which do not require treatment at a skilled nursing facility level of care....[A]t the time of admission to this facility, the member required maximum assistance for bed mobility, bathing, dressing and toileting, and was non-ambulatory due to her lower extremity ulcers....[T]he member has not been able to participate regularly with skilled therapy due to complaints of pain....[T]he records provided for review do not show that the member has produced a significant change in her functional activities with the therapies she has received to date....[T]he member no longer has a medical need for skilled care....[F]unctionally, the member does not have an expectation for practical improvement within a predictable time period with further skilled nursing facility care....

[I]t is not medically necessary for the member to be treated at a skilled nursing facility level of care starting 5/24/11.

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 finds that BCBSM's denial of coverage for additional skilled nursing

care was medically correct and consistent with the terms of the Petitioner's certificate of coverage.

**V. ORDER**

The Commissioner upholds BCBSM's May 27, 2011, final adverse determination. BCBSM is not required to provide additional coverage for additional skilled nursing care.

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.

---

R. Kevin Clinton  
Commissioner