

**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**

**XXXXXX**

**Petitioner**

**File No. 117402-001**

**v**

**Blue Cross Blue Shield of Michigan  
Respondent**

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**Issued and entered  
this 20th day of June 2011  
by R. Kevin Clinton  
Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On November 16, 2010, XXXXX, authorized representative of her husband 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, MCL 550.1901 *et seq.* The case was accepted for review on November 23, 2010.

Because it involved medical issues, the case was assigned to an independent review organization which provided its analysis and recommendations on December 7, 2010.

**II. FACTUAL BACKGROUND**

The Petitioner receives health care benefits as an eligible dependent under his wife's group coverage. Their benefits are defined in the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The Petitioner has a history of peripheral vascular disease. He had surgery to remove his right leg and two toes on his left leg and, on December 28, 2009, he was transferred to XXXXX, LLC, a skilled nursing facility. BCBSM denied coverage for the care at XXXXX from March 6 to 23, 2010.

The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. After a managerial-level conference on October 20, 2010, BCBSM did not change its decision and issued a final adverse determination dated October 27, 2010.

### III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's care at XXXXX from March 6 to March 23, 2010?

### IV. ANALYSIS

#### Petitioner's Argument

The Petitioner is very disappointed that BCBSM denied 17 days of his stay at XXXXX. He argues that this care was medically necessary and a covered benefit under his BCBSM certificate. He believes that BCBSM is required to pay for his care during the listed period.

#### BCBSM's Argument

BCBSM says that under the terms of the certificate, services must be medically necessary to be covered. BCBSM's medical consultants reviewed the documentation and decided that it did not establish that the criteria for skilled nursing facility care had been met. In particular, there was no evidence that the Petitioner met the therapy guidelines for the minimum therapy of five times per week during his stay, and no skilled medical needs were identified.

BCBSM denied coverage for the care at XXXXX, stating that the Petitioner could have been managed in a basic level of care or alternative setting. Further review by peer review physicians found that the Petitioner had therapies primarily only on two days out of the 17 day stay and they believed he could have been managed at a different level of care.

BCBSM submits that the denial of the care at XXXXX was correct and according to the terms of the Petitioner's certificate.

#### Commissioner's Review

The certificate (p. 7.14) requires that a service must be medically necessary to be covered. "Medical necessity" (as it relates to other than professional services or hospitals) is defined on p. 7.15 of the certificate:

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or

physician.

- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

**NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.**

The question of whether the Petitioner's care at XXXXX was medically necessary was presented to an independent medical 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 Family Medicine. The reviewer is a member of the American Academy of Family Physicians and is a clinical instructor at a college of medicine. The IRO reviewer's report included the following conclusions and analysis:

It is the determination of this reviewer that skilled nursing care was medically necessary for the dates of service March 6, 2010 – March 23, 2010.

\* \* \*

Due to the enrollee's need for intensive assistance with ADL's, limited mobility, need for physical therapy (PT) and gait training along with multiple comorbidities, including COPD and delirium; this enrollee could not be safely rehabilitated in a less intensive setting. Even in the skilled nursing facility (SNF) setting, the enrollee fell while transferring from bed to wheelchair. The overall complexity of this enrollee's condition required skilled nursing involvement to manage a plan for the total care needed, to observe his progress, and to evaluate the need for changes in the treatment plan.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO's 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 care in question was medically necessary for treatment of Petitioner's condition and therefore is a covered benefit under the certificate.

## V. ORDER

Respondent BCBSM's March 19, 2010, final adverse determination is reversed.

BCBSM is required to provide coverage for the Petitioner's care at XXXXX, LLC, from March 6 to 23, 2010. Coverage is to be provided within 60 days from the date of this Order with proof of compliance provided to the Commissioner within seven days of compliance.

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

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 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