

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. 118685-001

v

Blue Cross Blue Shield of Michigan

Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On December 22, 2010, XXXXXX (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.* On January 3, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Since this case involves medical issues, the Commissioner assigned the case to an independent medical review organization which provided its recommendation on January 14, 2011.

II. FACTUAL BACKGROUND

The Petitioner's benefits are defined in the Blue Cross Blue Shield of Michigan (BCBSM) *Community Blue* certificate of coverage.

On January 12, 2010, Petitioner was admitted to a skilled nursing facility, XXXXXX Center in XXXXXX. She was discharged April 16, 2010. BCBSM provided coverage for the period January 12 through March 19, 2010. BCBSM denied care beyond March 19 after concluding that care could have been provided in a custodial setting after that date.

The Petitioner appealed BCBSM's decision through BCBSM's internal grievance process. After a managerial-level conference on September 8, 2010, BCBSM did not change its decision and issued a final adverse determination on October 22, 2010.

III. ISSUE

Is BCBSM required to provide coverage for Petitioner's stay at XXXXX Center from March 20 through April 6, 2010?

IV. ANALYSIS

Petitioner's Argument

Petitioner's husband argues that his wife's care through April 6, 2010, should be covered by BCBSM because she was unable to care for herself or to safely climb stairs. Additionally, there was no one to care for her at home since he was in the same nursing facility recovering from a hip replacement. Petitioner's husband also states that his wife's physical and occupational therapists did not believe that Petitioner was ready to care for herself and should have remained at the skilled nursing facility during that time. For these reasons, Petitioner and her husband believe BCBSM is required to provide coverage for her stay at XXXXX for the period of March 20 through April 6, 2010.

BCBSM's Argument

In its October 22, 2010, final adverse determination addressed to the Petitioner's husband, BCBSM denied coverage for additional days in the skilled nursing facility beyond March 19, 2010:

Our medical consultants as well as XXXXX reviewed the records through March 25, 2010. It was their decision that your wife could have been treated in a lesser setting after March 19. During the period of March 20 through March 25, your wife was at a high functional level. Therefore, she no longer met our criteria for an inpatient setting.

BCBSM maintains that the services Petitioner received at XXXXX after March 19, 2010, was not skilled care but was custodial care. BCBSM also determined that Petitioner's care could be managed at home as she was able to perform basic activities of daily living either independently or under supervision. In addition, there were no records provided for the time period of March 25 through April 6, 2010 to determine if skilled care was provided.

BCBSM maintains that any additional therapy required of the Petitioner could be provided in a non-skilled setting.

Commissioner's Review

The *Community Blue* certificate of coverage, in section 3, describes the length of stay authorized in a skilled nursing facility:

Length of Stay

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

Services That Are Not Payable

- We do not pay for:
- Custodial care
- Care for senility or mental retardation
- Care for substance abuse

To answer the question of whether it was medically necessary for the Petitioner to have been treated at a skilled nursing facility level of care from March 20 through April 6, 2010, the Commissioner presented that issue to an independent medical review organization (IRO) for review. The IRO reviewer is a physician who is board certified in physical medicine and rehabilitation and has been in active practice for more than 12 years. The IRO reviewer's report included this analysis:

[G]enerally accepted criteria for coverage of skilled nursing facility services require that a patient must need skilled nursing and/or skilled rehabilitation services that as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis and there must be an expectation for practical improvement with realistic goals. . . . [T]he member was medically stable as of 3/19/10 and did not have skilled nursing needs. . . . [T]he physician orders and nursing notes provided in the case file demonstrate that the member received custodial level monitoring and care. . . . [F]unctionally, the member was modified independent ambulating 75 feet times 2 with a rolling walker, independent with bed mobility, and independent to modified independent with transfers, and that she required minimum assistance with bathing and lower extremity dressing. . . . [T]he member had plateaued in her mobility and activities of daily living for 2 weeks prior to 3/19/10. . . . [A]s of 3/19/10, the member did not have a reasonable expectation for further practical improvement with continued skilled nursing facility rehabilitation. . . . [T]he member did not demonstrate rehabilitation or medical issues consistent with a need for continued skilled nursing facility care as of 3/19/10 and was at a custodial level of care.

The IRO reviewer determined that it was not medically necessary for the Petitioner to have been treated at a skilled nursing facility from March 19 to April 6, 2010.

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 continued skilled nursing facility services from March 20 through April 6, 2010 was consistent with the terms of the certificate.

V. ORDER

Respondent BCBSM's October 22, 2010, final adverse determination is upheld. BCBSM is not required to provide coverage for the skilled nursing facility services the Petitioner received from March 20 through April 6, 2010.

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.

R. Kevin Clinton
Commissioner