

STATE OF MICHIGAN  
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES  
Before the Director of Insurance and Financial Services

In the matter of:

██████████, Petitioner,

v

File No. 145406-001-SF

██████████, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

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Issued and entered  
this 16<sup>th</sup> day of January 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On December 15, 2014, ██████████, authorized representative of his brother ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On December 22, 2014, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a plan sponsored by the ██████████ (the plan), a self-funded governmental health plan subject to Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on December 30, 2014.

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

To address the medical issues in the case, the Director assigned it to an independent medical review organization which provided its report and recommendation on January 8, 2015.

**II. FACTUAL BACKGROUND**

The plan's benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC*<sup>1</sup> (the certificate).

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<sup>1</sup> BCBSM form no. 457F, effective 07/14.

On September 17, 2014, the Petitioner was admitted to the hospital. On October 24, 2014, he was transferred to [REDACTED], a skilled nursing facility, for further care. The Petitioner remained in the facility until December 8, 2014.

On November 30, 2014, BCBSM declined to recertify coverage for skilled nursing facility care beyond December 1, 2014, and the Petitioner's authorized representative initiated an expedited appeal of that decision through BCBSM's internal grievance process. At the conclusion of its grievance process, BCBSM issued a final adverse determination dated December 5, 2014, upholding its decision. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's care in a skilled nursing facility for the period of December 1 through December 8, 2014?

### IV. ANALYSIS

#### BCBSM's Argument

In its final adverse determination, BCBSM explained to the Petitioner's authorized representative:

. . . After review, I confirmed that [the Petitioner] does not meet the medical criteria for additional days in the skilled nursing facility and the denial is maintained. His last covered day remains December 1, 2014.

[The Petitioner] is covered under the *Community Blue Group Benefit Certificate ASC* which details the skilled nursing facility benefits on Page 87 and 88. The certificate states that 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.

Your brother's records and your request for a skilled nursing facility with physical therapy and occupational therapy were reviewed by our medical consultant using the InterQual Criteria for debility with medical co-morbidities. After review, the medical consultant determined that [the Petitioner] was in the facility for a period of 38 days and over the duration he was functioning at a high level requiring only contact guard for transfers, bed mobility, ambulation and going up and down stairs. By December 1, 2014 [he] had developed increased Ammonia levels which were being managed with oral lactulose and rifaximin. He was on a regular diet and going around the facility in a wheelchair at will. This demonstrates that his care could be managed at an alternative facility - home with home health care or a long-term facility. Therefore, a further stay past December 1, 2014 is not approved.

#### Petitioner's Argument

In the request for an external review, the Petitioner's authorized representative wrote:

[The Petitioner] spent 38 days in [REDACTED]. He is rehabilitating at [REDACTED]. His skilled nursing benefit from BCBSM was discontinued even though the PT and OT therapists indicated he could use more rehabilitation. He also had elevated levels of ammonia, a urinary infection and fluctuating lithium levels and needed frequent blood draws to monitor various aspects of his blood.

The Petitioner wants BCBSM to cover his skilled nursing facility care past December 1, 2014.

### Director's Review

The certificate, under "Skilled Nursing Facility Services" (p. 87) says:

Locations: We pay for facility and professional services in a skilled nursing facility.

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#### 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 days per member, per calendar year.

To determine if it was necessary for the Petitioner to be in a skilled nursing facility after December 1, 2014, the Director presented the issue to an independent review organization (IRO) for analysis and a recommendation, as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO physician consultant is certified by the American Board of Physical Medicine and Rehabilitation; a prior medical director of rehabilitation at a hospital; extensively published in the peer reviewed medical literature; and in active practice. The IRO report included the following:

#### **Reviewer's Decision and Principal Reason for the Decision:**

It is the determination of this reviewer that the continued skilled nursing facility services after December 1, 2014 was not medically necessary for the treatment of the enrollee's condition.

#### **Clinical Rationale for the Decision:**

The criteria per Medicare and InterQual, indicates that for a patient to be a candidate for ongoing skilled nursing facility care, the patient should have specific goals requiring 1 hour daily of skilled nursing or therapy needs which cannot be met in a lesser level of care. The documentation submitted for review indicates the enrollee was functioning at a high level and required only contact guard for transfers, bed mobility, ambulation, and stairs. He required minimal or standby assistance for some activities of daily living. By December 1, 2014 he had increased ammonia levels which were being managed with oral lactulose and Rifaximin and the enrollee was on a regular diet. The medical records indicate that this appeal was requested because the enrollee's liver functions were being monitored in the skilled nursing facility setting. The enrollee's continued therapy, as well as ongoing monitoring of the enrollee's liver status could be safely performed at a lower

level of care. The medical records submitted for review do not provide a rationale or clinical evidence as to why the enrollee continued to require skilled nursing facility care. Therefore, the continued skilled nursing facility services after December 1, 2014 was not medically necessary.

**Recommendation:**

It is the recommendation of this reviewer that the denial by [BCBSM] for the continued admission on December 1, 2014 at a skilled level of care be upheld.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise, and professional judgment. Furthermore, it is not contrary to any provision of the Petitioner's certificate of coverage. MCL 550.1911(15).

The Director, discerning no reason why the IRO's recommendation should be rejected in this case, finds that skilled nursing facility care for the Petitioner after December 1, 2014, was not medically necessary and is therefore not a covered benefit under the certificate.

**V. ORDER**

The Director upholds BCBSM's final adverse determination of December 5, 2014.

This is a final decision of an administrative agency. 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 Michigan county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director