

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. 147516-001-SF

State of Michigan, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 27th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 24, 2015, ██████████ (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 May 1, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request.

The Petitioner receives health care benefits through a plan sponsored by the State of Michigan (the plan), a self-funded governmental health plan as defined in Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan and issued a final adverse determination regarding benefits that the Petitioner wants the Director to review.

The Director immediately notified BCBSM of the request for external review and asked for the information it used to make its final adverse determination. BCBSM responded on May 12, 2015.

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 issue in this case, the Director assigned it to an independent medical review organization which provided its analysis and recommendation on May 15, 2015.

II. FACTUAL BACKGROUND

The Petitioner's benefits are described in the plan's *Your Benefit Guide - State Health Plan PPO for Non-Medicare Retirees* (the benefit guide).¹

The Petitioner, following hospitalization, was admitted to a skilled nursing facility on March 25, 2015.² He was approved for care in the facility for 15 days (March 25 through April 8, 2015). When a request for additional days was made, BCBSM denied it on the basis that the Petitioner did not meet the criteria for skilled nursing care after April 8, 2015.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and issued a final adverse determination dated April 14, 2015, upholding its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for skilled nursing care after April 8, 2015?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination BCBSM told the Petitioner:

. . . A board-certified D. O. in Physical Medicine Rehabilitation reviewed your appeal request and your health care plan benefits. . . . Based on that review, our consultant determined the following:

Your appeal request for the approval of physical and occupational therapy in a skilled nursing facility was reviewed by first applying InterQual criteria for Skilled Nursing Facility Level 1. Our review shows that you received therapy at a skilled nursing facility since March 25, 2015 due to pneumonia and a recent right knee surgery.

As of April 8, 2015, you were independent with bed mobility and were able to walk 150 feet with a wheeled walker and standby assistance. You required standby assistance or supervision for basic self-care skills like bathing, dressing and toileting. You needed minimal assistance for lower body dressing. Your care does not require a continuing stay in a skilled nursing facility. Our review suggests that your care can be managed in an alternative setting, including home with home health care services and family support or

¹ Effective October 1, 2014.

² Skilled nursing care is a benefit under the plan (benefit guide, pp. 29-30).

if this this not possible, then in a long term care center. Therefore this request was not approved.

Page 29 of Your Benefit Guide State Health Plan PPO for Non-Medicare Retirees explains that your coverage includes skilled nursing care in an approved nursing facility, when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In this case, our consultant determined that you do not meet the criteria to continue your services in a skilled nursing facility. Therefore, we are unable to approve precertification of additional days for your skilled nursing services.

Petitioner's Argument

In his request for an external review the Petitioner wrote:

Blue Cross denied my coverage for rehabilitation at a skilled nursing facility where I am recovering from knee surgery and pneumonia. I continue to benefit from this care and plan to return home as soon as I am able. Dates of non-coverage are from 4/9/15 through present.

In an April 22, 2015, letter filed with the request for an external review, the skilled nursing facility's medical director wrote:

... [The Petitioner] continues to require rehabilitative stay in Skilled Nursing Facility, due to his physical limitations, which would be unsupported in his home environment. His multiple medical conditions would place his recovery in jeopardy, with the likely of regression instead of progress in other than a 24-hour setting.

[He] continues to require nursing home care while he is recovering and rehabilitating following R knee total arthroplasty and recurrent pneumonia. He has a history of complications prior to his arthroplasty, including RLE DVT [*right lower extremity deep vein thrombosis*], post Greenfield filter placement, chronic RLE edema, history of possible RLE fracture in the distant past. He had bariatric surgery, with a 300 lb. weight loss.

His physical rehabilitation is coming along slowly. He had a setback in his recovery, as pneumonia recurred on 4/12/15. He developed a persistent fever reaching to 101.7. He has been treated with Rocephin. He continues a productive cough, yellow sputum, and muscle weakness.

He has also required nursing home rehabilitation care due to his complex medical history which includes: a-fibrillation, post cardioversion on 3/13/15, initially successful, but with return of a-fib. His cardiologist planned an ablation, following his recovery and return to his home.

He is participating and slowly improving in physical and occupational therapy. Facility social worker is assisting him with discharge planning. In tandem with

our physical and occupational therapy team, we anticipate his transition to his home to take place within the next two weeks.

It is my professional opinion that Skilled Nursing Care is warranted for [him], until such time as he is physically and medically ready for discharge to his home.

Director's Review

BCBSM said the Petitioner did not meet criteria for additional skilled nursing facility care, i.e., it was not medically necessary. To evaluate that conclusion, the Director presented the issue to an independent review organization (IRO) for analysis, as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO physician reviewer is board certified in geriatrics and has been in active practice for more than 15 years. The IRO report included the following analysis and recommendation:

Recommended Decision:

The MAXIMUS physician consultant determined that it has been medically necessary for the member to be treated at a skilled nursing facility level of care after 4/8/15.

Rationale:

* * *

The member has a medical history of obesity, status post bariatric surgery, atrial fibrillation, prior deep vein thrombosis and degenerative joint disease, which led to right total knee replacement on 3/21/15. The member subsequently developed pneumonia and was hospitalized on 3/23/15 where he remained until 3/25/15, when he was discharged to a nursing facility to receive skilled nursing care. The health plan covered the skilled facility services provided through 4/8/15.

The Maximus physician consultant indicated that the records provided for review show that the member received skilled rehabilitation therapies and made slow progress with therapy. The member has ongoing respiratory symptoms. The physician consultant explained that the records provided for review point to poor safety awareness, which may relate to ongoing medical issues, including cognitive impairment as a medication side effect. The consultant also explained that the member was not safe for discharge as of 4/8/15 and as a practical matter, he could not have continued to receive needed daily skilled therapies and skilled monitoring in an alternative setting. The consultant indicated that based on the member's baseline functional status and progress to date, meaningful measureable gains would be anticipated to occur with continued skilled rehabilitative therapies.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it has been medically necessary for the member to be treated at a skilled nursing facility level of care after 4/8/15.

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 experience, expertise, and professional judgment. In addition, the IRO's recommendation is not contrary to the terms of coverage in the benefit guide. MCL 550.1911(15).

The Director, discerning no reason to reject the IRO's recommendation, finds that the skilled nursing facility care provided the Petitioner after April 8, 2015, is medically necessary and a covered benefit under the terms of the Petitioner's coverage.

V. ORDER

The Director reverses BCBSM's final adverse determination of April 14, 2015.

The plan shall immediately cover medically necessary skilled nursing facility care for the Petitioner after April 8, 2015, and shall, within seven days of providing coverage, furnish the Director with proof it has complied with this Order.

To enforce this Order, the Petitioner may report any complaint regarding its implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, at this toll free number: (877) 999-6442.

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.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director