

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. 154642-001

Blue Cross Complete of Michigan,

Respondent.

Issued and entered
this 22nd day of August 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage for part of a stay at a skilled nursing facility. Her health plan, Blue Cross Complete of Michigan, Inc. (BCC), said she did not require continuing skilled care.

On July 19, 2016, ██████████, the Petitioner's authorized representative, filed a request with the Director of Insurance and Financial Services for an external review of BCC's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on July 26, 2016.

The Petitioner receives health care benefits through BCC, a Medicaid health maintenance organization. The Director immediately notified BCC of the external review request and asked for the information it used to make its final adverse determination. The Director received BCC's response on July 29, 2016.

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 August 10, 2016.

II. FACTUAL BACKGROUND

The Petitioner's benefits are described in BCC's *Member Handbook* (the handbook).

The Petitioner was admitted to a skilled nursing facility on February 24, 2016, following her release from the hospital. She remained at the facility until April 10, 2016. BCC covered her care from February 24 through March 23, 2016, but denied coverage for care beyond that point because she did not meet the coverage criteria for skilled care.

The Petitioner appealed the denial through BCC's internal grievance process. At the conclusion of that process, BCC issued a final adverse determination dated May 27, 2016, upholding its decision. The Petitioner now seeks a review of BCC's final adverse determination from the Director.

III. ISSUE

Did BCC correctly deny coverage for skilled nursing care after March 23, 2016?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination BCC explained its decision to the Petitioner:

... Your appeal request was reviewed by an AmeriHealth Caritas Blue Cross Complete Medical Director who is a Medical Doctor board certified in Family Medicine. The Medical Director has approved continued admission to March 24, 2016. The Medical Director decided to uphold (agree with) the original denial for continued admission from March 24, 2016 to discharge (April 10, 2016).

Your appeal is denied. Blue Cross Complete denied your appeal because:

Available records were looked at. Medical need guidelines for sub-acute care admission were looked at. The notes show that IV antibiotics were stopped after March 23, 2016. The notes do not show required skilled care needs. Continued admission from March 24, 2016 to discharge (April 10, 2016) is not approved.

Petitioner's Argument

In an April 12, 2016, letter submitted with this request for an external review, a nurse from the facility wrote:

[The Petitioner] was admitted to this facility on February 24, 2016 ... for IV antibiotic therapy.

[The Petitioner] was admitted to the acute care hospital for treatment of bacterial sepsis secondary to a renal calculus that was obstructing her urinary tract and causing urinary retention. She was seen by infectious diseases in the hospital, who recommended 6 weeks of IV antibiotic therapy, which the patient was unable to have provided in her home. She was picked up for a short time for skilled occupational therapy, but was largely independent with self-care, leading to a discharge from skilled therapy on March 9, 2016.¹ As is reflected in the Medication Administration Record, the patient continued to receive IV antibiotics regularly following her discharge from skilled therapy. Furthermore, facility case management learned from the Blue Cross Complete representative who called in response to the original clinical update that the patient was homeless, at which time the Social Services director initiated contact to other community agencies in hopes of assisting [her] to find placement.

Director's Review

The handbook (p. 14) covers medically necessary care in a skilled nursing facility. "Medically necessary" is defined in the handbook (p. 66) as

services and supplies furnished to a Member when and to the extent the Blue Cross Complete Medical Director or his or her designee determines that they satisfy all of the following criteria:

- They are medically required and medically appropriate for the diagnosis and treatment of the Member's illness or injury;
- They are consistent with professionally-recognized standards of health care;
- They do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the Member's illness or injury.

The fact that a physician may have prescribed, ordered, recommended, or approved the provision of certain services to the Member does not necessarily mean that such services satisfy the above criteria.

To determine if BCC correctly denied coverage for a portion of the Petitioner's stay in a skilled nursing facility, the Director presented the issue to an independent review organization (IRO) as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

¹ The Petitioner received occupational therapy at the facility until March 9, 2016, and continued antibiotic therapy until March 23, 2016.

The IRO physician reviewer is board certified in internal medicine and has been in active practice for more than 18 years. The IRO report included the following analysis and recommendation:

Recommended Decision:

The MAXIMUS physician consultant determined that it was not medically necessary for the member to have been treated at a skilled nursing facility level of care from 3/24/16 to 4/10/16.

Rationale:

* * *

The results of the consultant's review indicate that this case involves a 22 year-old female who received inpatient treatment for bacterial sepsis and was transferred to a skilled nursing facility on 2/24/16. At issue in this appeal is whether it was medically necessary for the member to have been treated at a skilled nursing facility level of care from 3/24/16 to 4/10/16.

Bacterial sepsis refers to symptomatic bacteremia, with or without organ dysfunction. Sepsis is commonly defined as the presence of infection in conjunction with the systemic inflammatory response system. Sepsis is usually associated with other conditions. In this case, the member's sepsis was secondary to urinary retention due to a renal calculus. Patients with sepsis are generally ill and require bed rest or admission to an intensive care unit for monitoring and treatment. Treatment includes determination of the likely source of infection, administration of intravenous antibiotics, supportive therapy aimed at maintaining organ perfusion and respiratory support, when necessary. The goals of pharmacotherapy are to eradicate the infection, reduce morbidity and prevent complications.

The MAXIMUS physician consultant indicated that the member was evaluated in the hospital for bacterial sepsis and was appropriately treated. The member received occupational therapy in the skilled nursing facility until 3/9/16 and continued to receive antibiotic therapy until 3/23/16. The physician consultant explained that for the period from 3/24/16 to 4/10/16, the member required no skilled level of care services. The consultant indicated that the member did not require skilled nursing or skilled therapy services to prevent deterioration in her condition or to establish an effective maintenance program as of 3/24/16. The consultant also indicated that the member was medically stable during the period at issue in this appeal.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it was not medically necessary for the member to have been treated at a skilled nursing facility level of care from 3/24/16 to 4/10/16. [References omitted]

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 skilled nursing care was not medically necessary for the Petitioner after March 23, 2016, and that BCC correctly denied coverage for her stay in the skilled nursing facility beyond that date.

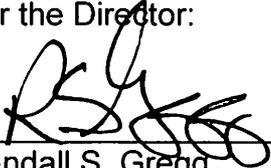
V. ORDER

The Director upholds BCC's final adverse determination.

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