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

XXXXX
Petitioner
v **File No. 122076-001-SF**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _22nd_ day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 27, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on July 5, 2011.

The Petitioner receives health care benefits through the *State Health Plan PPO*, a self-funded account. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 14, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM's *State Health Plan PPO* benefit guide for retirees not eligible for Medicare. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On June 17, 2010, the Petitioner was involved in a car accident in XXXXX. She was hospitalized until June 24, 2010. At the time of her release she was unable to care for herself so skilled nursing facility care was requested and BCBSM approved the care. Petitioner entered the XXXXX Healthcare Facility in XXXXX where she remained until July 27, 2010.

BCBSM subsequently denied the skilled nursing facility care provided by XXXXX because it is a nonparticipating provider. Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference and upheld its denial in its final adverse determination letter dated June 15, 2011.

III. ISSUE

Is BCBSM required to pay for Petitioner's skilled nursing facility care?

IV. ANALYSIS

Petitioner's Argument

In her request for review, the Petitioner wrote:

> On 6-15-11 BCBSM informed me that they had made their final decision to deny payment of $1,530.90 and $5,686.20 to XXXXX because it is non-PPO but BCBSM had pre-approved me to be released from XXXXX Hosp. to XXXXX and sent me 2 approval letters. I think BCBSM should pay since they are the ones who would know if XXXXX was in their system or not. I would not have gone to XXXXX if I had known.

BCBSM's Argument

In its final adverse determination of June 15, 2011, BCBSM denied the skilled nursing facility care:

> As explained within *The State Health Plan PPO for retirees not eligible for Medicare*, you are responsible for 100 percent of skilled nursing services rendered by a nonparticipating provider. As you know, XXXXX Healthcare Facility is a nonparticipating provider.
>
> The letters of authorization issued to you from our Continuum of Care Unit provided approval based on the medical information submitted. However, the letter also states that the service(s) must meet several conditions. One condition included in the list is as follows.

- The service(s) must be rendered at a participating Blue Cross Blue Shield facility. Claims for services performed at a nonparticipating Blue Cross Blue Shield facility may not be paid depending on the member's group benefits. Please check your benefits for your specific coverage requirements.

Commissioner's Review

Under the benefit guide, skilled nursing care is only covered if provided by a participating provider. Page 57 of the benefit guide includes the following chart:

Skilled Nursing Care

What you pay for covered services	
Participating	Nonparticipating
Annual in-network deductible	100%

Members have 120 skilled nursing days per admission. Care must be received in a BCBSM-approved skilled nursing facility. . . .

The Commissioner can understand why the Petitioner feels aggrieved. The Petitioner is correct that it would have been a simple matter for BCBSM to confirm the participation status of XXXXX since BCBSM's own approval letters of June 25 and July 9, 2010, list XXXXX as the facility where the Petitioner was to receive care. Nevertheless, the Commissioner is limited to adjudicating whether BCBSM has correctly applied the terms of its certificate of coverage. In this case, BCBSM did correctly apply the provision which excludes coverage for skilled nursing care provided at nonparticipating facilities.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 15, 2011, is upheld. BCBSM is not required to pay for the Petitioner's June 24, 2010 through July 27, 2011, care at XXXXX.

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 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner