STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Pensacola A. Smith, Appellant, vs. South Carolina Public Employee Benefit Authority, Employee Insurance Program, Respondent.	Docket No.: 19-ALJ-30-0237-AP **ORDER**

STATEMENT OF THE CASE

The above-captioned matter is before the Administrative Law Court (ALC or Court) on an administrative appeal pursuant to S.C. Code Ann. § 1-11-710(C) (2005) and S.C. Code Ann. § 1-23-600(D) (Supp. 2019). Pensacola A. Smith (Appellant), a retired teacher of the South Carolina public school system, seeks review of a decision by the South Carolina Public Employee Benefit Authority (PEBA) denying coverage for her skilled nursing facility (SNF) rehabilitation treatment from January 18, 2015, through February 28, 2015. Appellant participated in the Medicare Supplemental Plan, an option under the South Carolina Group Health Benefits Plan (Plan). BlueCross BlueShield of South Carolina (BlueCross or BCBS) was the third-party claims administrator for the Plan. PEBA denied Appellant's Appeal because: (1) Appellant's SNF treatment was not pre-certified, (2) the SNF treatment was considered long term rehabilitation, and (3) the SNF treatment was deemed to not have been medically necessary. Based upon a thorough evaluation of the Record on Appeal (Record) and parties' arguments, the Court affirms PEBA's decision to deny benefits.

STANDARD OF REVIEW

The enabling legislation for the Plan provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by [PEBA], which shall constitute the exclusive remedy for these claims, <u>subject only to</u>

appellate judicial review consistent with the standards provided in Section 1-23-380.

S.C. Code Ann. § 1-11-710(C) (2005) (Emphasis added).

The Court's review of this case is in an appellate capacity under the standards of S.C. Code Ann. § 1-23-380 (2005 and Supp. 2020), rather than as an independent finder of fact. Specifically, § 1-23-380(5) provides:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision [of the agency] if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

When applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct and will only be set aside if unsupported by substantial evidence. *Rodney v. Michelin Tire Co.*, 320 S.C. 515, 519, 466 S.E.2d 357, 359 (1996). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. *Grant v. S.C. Coastal Council*, 319 S.C 348, 353, 461 S.E.2d 388, 391 (1995). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. *Waters*, at 226, 467 S.E.2d at 917.

A decision is supported by substantial evidence when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. *Bilton v. Best Western Royal Motor Lodge*, 282 S.C. 634, 641, 321 S.E.2d 63, 68 (Ct. App. 1984). The well-settled case law in this State has also interpreted the substantial evidence rule to mean that a decision will not be set aside simply because reasonable minds may differ on the judgment. *Lark v. Bi-Lo*, 276 S.C. 130, 136, 276 S.E.2d 304, 307 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not

prevent the agency's finding from being supported by substantial evidence. *Waters v. S.C. Land. Res. Conservation Comm'n*, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996).

Nevertheless, a reviewing court is not so constrained when deciding questions of law. *See Gibson v. Ameris Bank*, 420 S.C. 536, 542, 804 S.E.2d 276, 279 (Ct. App. 2017) ("[Q]uestions of law may be decided with no particular deference to the trial court….") (quoting *U.S. Bank Tr. Nat'l Ass'n v. Bell*, 385 S.C. 364, 373, 684 S.E.2d 199, 204 (Ct. App. 2009)); *see also Flexon v. PHC-Jasper, Inc.*, 413 S.C. 561, 569, 776 S.E.2d 397, 402 (Ct. App. 2015) ("This court [Court of Appeals] reviews questions of law de novo.") (quoting *Proctor v. Steedley*, 398 S.C. 561, 573, 730 S.E.2d 357, 363 (Ct. App. 2012)). However, "[t]he construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons." *Dunton v. S.C. Bd. of Examiners In Optometry*, 291 S.C. 221, 223, 353 S.E.2d 132, 133 (1987) citing *Emerson Electric Co. v. Wasson*, 287 S.C. 394, 339 S.E.2d 118 (1986).

ISSUES ON APPEAL [1]

1. **Does substantial evidence exist to support PEBA's determination that Appellant's period of SNF treatment is ineligible for coverage under the Plan?**
2. **Does substantial evidence exist to support PEBA's determination that BlueCross' misinformation given to Appellant did not affect Appellant's belief of coverage?**

PROCEDURAL AND FACTUAL BACKGROUND

Appellant had been covered under the Medicare Supplemental Plan since 1998. [2] After having suffered a stroke, Appellant began a period of pre-certified SNF treatment on October 14, 2014. [3] For SNF services, Medicare will pay up to 100 days of SNF treatment as primary payor

[1] The Issues on Appeal are largely set out as listed in Appellant's brief.

[2] Subject to certain limitations to be discussed, under the Medicare Supplemental Plan, Medicare provides primary coverage to eligible retirees. The Plan pays some or all remaining costs of eligible medical expenses as a secondary payor. *See* Plan paragraph 16.1.

[3] Paragraph 2.66 of the Plan defines "pre-certification or certification" as "the procedure through which a Covered Person may obtain a determination from a Utilization Review Agency that a proposed treatment, and length of stay determination, if required, is consistent with generally recognized medical standards and procedures." *See* R. 482. Additionally, paragraph 15.1.2.F of the Plan specifically identifies an admission or readmission to a skilled nursing facility as a type of medical service or treatment requiring precertification at least 48 hours or two days in advance, regardless of whether the Plan acts as primary or secondary payor of such treatment or services.

with the Plan paying remaining charges during this time as the secondary payor. [4] As determined by PEBA and supported by the Record, prior to the end of Appellant's 100 days of pre-certified SNF treatment, BlueCross informed her health care provider, Pruitt Health-Dillon, LLC (Pruitt Health) that pre-certification for continued SNF services beyond 100 days was necessary. On October 29, 2014, November 26, 2014, and January 14, 2015, BlueCross provided the same information regarding the need for pre-certification for Appellant's continued care to her son, Dr. Leo Smith, who holds a power of attorney to act on his mother's behalf. BlueCross later provided the same information in two additional calls to Dr. Smith on February 3, 2015, and April 20, 2015.

On January 17, 2015, Appellant completed 100 days of pre-certified SNF treatment, thus, exhausting her Medicare benefits. Appellant nevertheless continued SNF treatment from January 18, 2015, through January 31, 2015. These fourteen days of treatment were not pre-certified through BlueCross. Appellant thereafter continued SNF treatment from February 1, 2015, through February 28, 2015. These twenty-eight days of treatment were, similarly, not pre-certified.

On April 27, 2015, Dr. Smith called BlueCross and was incorrectly informed by a service representative that the Plan would cover Appellant's expenses for her continued SNF treatment. Thereafter, in July 2015, and September 2015, Pruitt Health filed claim numbers 20189E697-00-00 and 20181V759-00-01, respectively, with BlueCross seeking payment for the SNF services. The claim for 20189E697-00-00 was in the amount of $2,926.00 for the period January 18, 2015, through January 31, 2015. Claim 20181V759-00-01 was in the amount of $5,852.00 for the period February 1, 2015, through February 28, 2015. BlueCross subsequently sent Appellant Explanation of Benefits letters on July 17, 2015, and September 28, 2015, informing her that the respective claims were not covered because the treatments were not pre-certified. Appellant internally appealed these denials of coverage to BlueCross.

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[4] Specifically, Plan paragraphs 16.1.B.2(a)–(b) provide that for SNF charges, the Plan will pay as secondary payor for approved charges from the 21st day of treatment through the 100th day of treatment. The Plan will act as primary payor of SNF services extending beyond 100 days "if Medically Necessary and, and if approved by the Utilization Review Agency, for up to 60 days in any Plan Year." (Emphasis added)

The Record reveals that BlueCross reviewed Appellant's file on February 9, 2016, and determined that her SNF treatment was not medically necessary, in part based on BlueCross' CAM Policy 457: Inpatient Rehabilitation. [5] In pertinent part, this policy states:

> Inpatient physical rehabilitation [6] must meet the following admission guidelines:
>
> - services must be ordered by a physician and be directly related to a written treatment plan and goal;
> - the complexity and sophistication of the therapy and the patient's condition must require the judgment, knowledge and skill of a licensed/registered physical, occupational, speech therapist and/or neuropsychologist;
> - <u>there must be a reasonable expectation that the services will produce measurable improvement in the patient's condition in a reasonable and predicable time period</u>;
> - the services must be considered specific and effective for the patient's existing condition and the medical records must document that the patient is making progress.
>
> Non-admission guidelines include but are not limited to the following:
>
> - <u>treatment for maintenance therapy defined as activities that preserve the patient's present level of function and prevents regression of that function</u>;
> - treatment is repetitive exercises to maintain strength and endurance and/or for assisted walking for an unstable patient;
> - treatment is for range or motion and passive exercises that are not related to restoration of a specific loss of function, but are useful in maintaining range in paralyzed extremities;
> - the patient's physical condition and/or comprehension, judgment, memory, and reasoning are adequate to safely adapt to or perform basic activities of daily living.

(Emphasis added).

BlueCross determined that Appellant had met her maximum rehabilitation potential on January 2, 2015, because: (1) Appellant had been discharged to restorative nursing for

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[5] CAM Policy 457 was included in the Record; "CAM" apparently stands for "Corporate Administrative/Medical" Policies, and contains medical guidelines that may be used when making determinations in connection with a member's coverage under a health plan. The face of the document indicates that it is applicable to Blue Cross' "Administrative Services Only (ASO) Lines of Business" which would appear to include the Plan.

[6] The policy defines "inpatient physical rehabilitation" in pertinent part as "a program which consists of services and treatments dedicated to restoring maximum functional independence for individuals who have experience deficits secondary to traumatic or non-traumatic brain injury, SCI or associated neurological deficits, multi-trauma, CVA, amputations, orthopedic surgical interventions, ventilatory dependence/weaning or de-conditioning secondary to medical/surgical interventions."

ambulation to maintain her gains; and (2) although further functional improvement was theoretically possible, the documented gains were slow and the cause and effect relationship with formal treatment was unclear. It was further determined that Appellant did not meet required medical necessity criteria because (1) there was a failure to establish a reasonable expectation that the services would produce measurable improvement in Appellant's condition in a reasonable and predictable time period; (2) a failure to show that the services were specific and effective for the patient's existing condition; and (3) the medical records did not document Appellant was making progress. The Record contains a January 2, 2015 "Therapist Progress & Discharge summary." Under the heading "Reason for Discharge" is the explanation "Progress ceased." The document relates that of the nine (9) short term goals, Appellant satisfactorily met six and did not meet three (3) of the goals. For the identified Long Term Goal of "Bed Mobility Transfers – ambulation," as of January 2, 2015, the provider indicated that this goal had not been met with the annotation "Patient has made good progression since seen but feel she has met her maximum rehabilitation potential. Progress ceased." Under the section of the form titled "analysis of Functional Outcome./Clinical Impression", the following appears:

> Patient has been seen over the past months for treatment following a CVA affecting her left side and peripheral vision. She has made good progression which has slowed. Feel she has met her maximum rehabilitation potential with skilled therapy, progress ceased and she will transfer to Restorative for ambulation to maintain gains.

Based on its review, BlueCross upheld its denial of Appellant's claims.

On July 27, 2017, Dr. Smith formally appealed to BlueCross on Appellant's behalf, asserting that his mother's SNF treatment was medically necessary and that BlueCross had misinformed him that the SNF services would be covered. BlueCross upheld its original denial decisions in letters sent to Appellant on May 30, 2018, and July 18, 2018. BlueCross found that Appellant's SNF treatment was ineligible for coverage because it was not pre-certified and was not medically necessary as Appellant had met her maximum rehabilitation potential from skilled therapy. Dr. Smith then appealed to PEBA on Appellant's behalf on July 24, 2018. On June 14, 2019, PEBA upheld the denial of coverage for Appellant's SNF treatment from January 18, 2015, through February 28, 2015, finding the SNF treatment after the initial 100 days was not pre-certified and was not medically necessary. Appellant filed this appeal with the ALC on July 19, 2019. PEBA filed the Record on September 16, 2019. Thereafter, PEBA, with the consent of Appellant, filed a Motion to Amend the Record on Appeal, which was granted by the Court on

September 16, 2019. Appellant filed her brief on October 16, 2019. PEBA's brief was filed on November 13, 2019.

RELEVANT PLAN PROVISIONS

In addition to the Plan provisions referenced earlier, the following provisions of the Plan are pertinent:

> **2.50 Medical Necessity; Medically Necessary or Necessary Service and Supply**:
> A procedure, service or supply that meets all of the following criteria:
> A. Is required to identify or treat an existing condition, illness or injury; and
> B. Is prescribed or ordered by a Physician; and
> C. Is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
> D. Is required for reasons other than the convenience of the patient; and
> E. Results in measurable, identifiable progress in treating the Covered Person's condition, illness, or injury. (Emphasis added).
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> **7.9 Skilled Nursing Facility**
> Subject to all the terms, conditions, limitations and exclusions of the Plan including the limitation on Physician visits under paragraph 7.4.D.3. and the requirement that all admissions and readmissions to a Skilled Nursing Facility be Pre-certified by the Utilization Review Agency, the Plan will provide benefits for the Allowed Amount for room and board and a skilled nursing level of treatment in such facility for up to 60 days in any Plan Year. Refer to paragraph 16.1.B.2 for the Medicare Supplemental Plan benefits concerning Skilled Nursing Facility. (Emphasis added).
>
> **7.16 Rehabilitation Care**
> The Plan will provide benefits for physical rehabilitation designed to restore bodily function that has been lost because of trauma or disease process. The rehabilitation care may consist of physical therapy, speech therapy, occupational therapy, and therapy to teach ambulation, transfer technique, bed mobility, dressing, and therapy to teach ambulation, transfer technique, bed mobility, dressing, feeding technique, bowel and bladder training and other activities of daily living. For the purposes of this provision the following terms are defined as follows:
>
> **Acute Rehabilitation** shall refer to therapy beginning soon after the onset of illness or injury. In many cases, acute rehabilitation is appropriately done in an outpatient setting. In complex cases, the appropriate setting may be an acute care facility and then a subacute rehabilitation facility or a full-service rehabilitation unit. Acute rehabilitation may last days, weeks

or several months depending on the severity of illness or injury beginning soon after onset of illness or injury.

Long Term Rehabilitation shall refer to the point where further functional improvement is theoretically possible but the gains are slow and the cause/effect relationship with formal treatment is unclear. Benefits are not payable for long term rehabilitation after the acute rehabilitation phase.

Rehabilitation Care is subject to all terms and conditions of the Plan including the following:
A. Pre-certification is required for any inpatient rehabilitation care, regardless of the reason for the admission [. . .]

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E. Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient; [. . .]
G. Rehabilitation benefits are not payable for [. . .] long term rehabilitation after the acute rehabilitation phase [. . .] (Emphasis added).

DISCUSSION

1. Does substantial evidence exist to support PEBA's determination that Appellant's period of SNF treatment is ineligible for coverage under the Plan?

The Plan is an insurance contract, meaning this Court must determine the intention of the parties. "The cardinal rule of contract interpretation is to ascertain and give effect to the intention of the parties and, in determining that intention, the court looks to the language of the contract. If the language is clear and unambiguous, the language alone determines the contract's force and effect." *United Dominion Realty Trust, Inc. v. Wal-Mart Stores, Inc.*, 307 S.C. 102, 105, 413 S.E.2d 866, 868 (Ct. App. 1992) (citations omitted). "[Courts] should not torture the meaning of policy language in order to extend or defeat coverage that was never intended by the parties." *Gambrell v. Travelers Ins. Co.*, 280 S.C. 69, 310 S.E.2d 814 (1983) (overruled on other grounds by *State Farm Mut. Auto. Ins. Co. v. Horry*, 304 S.C. 165, 403 S.E.2d 318 (1991)). "When a contract is unambiguous, clear, and explicit, it must be construed according to the terms the parties have used, to be taken and understood in their plain, ordinary, and popular sense." *C.A.N. Enters., Inc. v. S.C. Health and Human Servs. Fin. Comm'n.*, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988). The court is limited to the interpretation of the contract made by the parties, regardless of its wisdom or folly, apparent unreasonableness, or failure of the parties to guard their rights carefully. *Id.* at 378, 373 S.E.2d at 587. The court is without authority to alter a

contract by construction or to make a new contract for the parties. *Id*. "It is the established law of this state that an insured is under the duty to comply with the conditions of his policy, before he will be entitled to recover benefits provided for therein." *Baker v. Metropolitan Life Ins. Co.*, 184 S.C. 341, 192 S.E. 571, 575 (1937). "The burden of proof is on the insured to show that a claim falls within the coverage of an insurance contract." *Sunex Int'l., Inc. v. Travelers Indem. Co. of Ill.*, 185 F. Supp. 2d. 614, 617 (D.S.C. 2001).

A. Medical Necessity Requirement

The plain language of the Plan provides that it will not pay for medical services that are not "medically necessary." [7] Substantial evidence supports PEBA's finding that the continued SNF treatment was not medically necessary. Appellant argues that BlueCross and PEBA found that further improvements from continued SNF treatment were theoretically possible after January 2, 2015, thus demonstrating that the treatments needed to be pursued to take the chance of continued improvement. However, paragraph 2.50 of the Plan states that one of the criteria that must be met for a treatment to qualify as medically necessary is that the treatment "results in measurable, identifiable progress in treating the Covered Person's condition, illness, or injury." Paragraph 2.50 elaborates further, stating:

> [t]he fact that a procedure, service or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not automatically mean that such procedure, service or supply is Medically Necessary or meets the definition of Medical Necessity under this Plan.

Despite Appellant's assertion that potential improvements from continuing the treatment were possible and that a physician ordered the treatments, substantial evidence supports PEBA's finding that the treatments were not medically necessary. "Medical necessity" is an objective standard to be applied by the trier of fact and it is not a delegation of power to the treating physician. *Marka Danielle Rodgers v. S.C. Public Employee Benefit Authority, Ins. Benefits*, 16-ALJ-30-0382-AP (November 1, 2017). Thus, the fact that Appellant's provider ordered the SNF

[7] Article 9 of the Plan, Exclusions and Limitations, states, in pertinent part, that "No benefits will be provided under any Article of the Plan, for any service, supply or charges for the following: A. Any service or charge for services <u>which is not Medically Necessary as defined in in paragraph 2.50</u>…" (Emphasis added).

services in question does not necessarily render those services medically necessary under the Plan.

Further, the fact that potential improvements were only theoretical also supports PEBA's finding that the continued SNF treatments constituted "long term", rather than "acute" rehabilitation. Since paragraph 7.16 of the Plan excludes payment for long-term rehabilitation services, substantial evidence supports PEBA's conclusion that Appellant's services were ineligible for coverage. [8] Although BCBS' appeals process allows a claimant to supplement the record with medical documentation to support a claim, Appellant submitted no medical records for additional consideration during the internal review process to support her claim that subsequent SNF treatments were medically necessary.

Accordingly, despite Appellant's arguments, there is substantial evidence to support PEBA's conclusions that Appellant's continued SNF treatments for the periods at issue were not medically necessary.

B. Pre-Certification Requirement

PEBA also cited Appellant's failure to obtain pre-certification as a ground for denial of coverage. Plan paragraphs 7.9 and 7.16 both indicate that all SNF admissions or readmissions require pre-certification to qualify for coverage. Moreover, paragraph 15.1.2.F requires that either the subscriber, a family member, or the subscriber's treating physician or provider contact the Utilization Review Agency for pre-certification at least 48 hours or two working days, whichever is greater, before receiving those services. The evidence in the Record supports that

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[8] Blue Cross' determination that Appellant had met her maximum rehabilitation potential on January 2, 2015, further undercuts Appellant's argument regarding the possibility of improvement. By this time, Appellant had been discharged to restorative nursing for ambulation to maintain the levels of function she had been able to gain from earlier SNF treatments. The Court acknowledges that there is evidence in the Record which suggests that Appellant was continuing to make some level of progress. Furthermore, there is also evidence which arguably suggests, at least in part, that Appellant's exhaustion of coverage contributed to her shift from acute therapy to restorative nursing, rather than due to an improvement in her condition. However, this case is not before the Court *de novo* for the purposes of trial, but instead the Court is acting in its appellate capacity. On appeal, the Court's inquiry is limited to determining whether there is substantial evidence to support PEBA's findings of fact. Among other documents in the Record, the January 2, 2015 Therapist Progress & Discharge Summary referenced earlier constitutes substantial evidence supporting PEBA's findings with the observation that Appellant "has met her maximum rehabilitation potential with skilled therapy, progress ceased and she will transfer to Restorative for ambulation to maintain gains." As set out earlier, the fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. *Waters v. S.C. Land. Res. Conservation Comm'n*, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996).

while both Pruitt Health and Dr. Smith were advised that Appellant's continued SNF treatment required pre-certification, BlueCross did not receive a timely request for pre-certification of these services. Since Appellant's SNF treatments from January 18, 2015, through February 28, 2015, were not pre-certified, substantial evidence supports PEBA's finding that extending coverage for these treatments would violate the terms of the Plan. [9]

2. Does substantial evidence exist to support PEBA's determination that BlueCross's misinformation given to Appellant did not affect Appellant's belief of coverage?

Appellant argues that she may recover under the tort of negligent misrepresentation and that further, that PEBA is estopped from denying coverage based on the fact that BlueCross provided her with incorrect information regarding the extent of her coverage. However, "claims for benefits under any self-insured plan of insurance offered by the State to . . . eligible individuals must be resolved by the procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (2005). Therefore, Appellant's claim for recovery here under the tort of negligent misrepresentation fails because it is a remedy outside of the procedures established by the board. Furthermore, subject matter

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[9] Neither party has discussed the meaning of paragraph 15.1.8.A. of the Plan as it relates to the effect of a failure to obtain pre-certification:

> A. Failure to Obtain Pre-Admission Review. A patient or Covered Person who does not obtain preadmission review and Pre-certification as required by this Article, in addition to the normal deductible and all other terms and conditions of the selected Plan, shall be subject to the following:
> 1. A $200 penalty for each admission to a Hospital of Skilled Nursing Facility;
> 2. The costs incurred during the hospitalization, treatment or extended benefit program shall not be included in those that satisfy the Coinsurance Maximum of paragraph 7.1.A.4 and 7.1.B.4;
> 3. The costs incurred during the hospitalization , treatment or extended benefit program shall always be subject to the Coinsurance requirement of the selected plan.

BCBS denied the Appellant's claims for continued SNF treatment in their entirety based on the lack of pre-certification and PEBA, upon consideration of the issue, also denied coverage. While on its face, this provision does not seem to support a complete denial of coverage for services rendered prior to obtaining the necessary pre-certification, PEBA's treatment of the issue, coupled with the Appellant's silence, leads the Court to the conclusion that Plan paragraph 15.1.8.A. does not provide Appellant any relief. Moreover, given the earlier determination that substantial evidence supported PEBA's conclusion that the additional SNF treatment was not medically necessary, and therefore, not covered under the Plan, the pre-certification or lack thereof has become a moot point.

jurisdiction over tort claims rests with South Carolina circuit courts and not the ALC. *Sabb v. South Carolina State University*, 350 S.C. 416, 421, 567 S.E.2d 231, 233 (2002) ("Sabb's tort action is clearly a part of the general class of cases which the court of common pleas has the jurisdiction to hear.")

Appellant's argument that the doctrine of estoppel applies to prevent PEBA from denying coverage for Appellant's claims must also fail. A party asserting estoppel against the government must prove, (1) lack of knowledge and of the means of obtaining knowledge of the truth as to the facts in question, (2) justifiable reliance upon the government's conduct, and (3) a prejudicial change in position. *Morgan v. S.C. Budget and Control Bd.*, 377 S.C. 313, 320, 659 S.E.2d 263, 267 (Ct. App. 2008). Here, BlueCross provided Appellant correct information regarding the extent of her coverage four times prior to undergoing the SNF treatment beyond the first 100 days. Although Appellant received incorrect information from BlueCross in April 2015, this communication occurred after the pre-certification deadline for the two claims in question and after Appellant completed the SNF treatment. Therefore, there is substantial evidence that Appellant's estoppel claim fails because Appellant and her son had knowledge of the truth as to the facts regarding coverage. Furthermore, Appellant could not have prejudicially changed her position in reliance on any incorrect information that was provided after she already completed the treatment. Accordingly, PEBA's conclusion that estoppel did not prevent the denial of Appellant's claims is supported by substantial evidence and Appellant's claims must be denied.

ORDER

IT IS HEREBY ORDERED that, for the reasons set forth above, PEBA's Final Agency Determination denying Plan coverage for Appellant's SNF treatment from January 18, 2015, to February 28, 2015, is **AFFIRMED**.

AND IT IS SO ORDERED.

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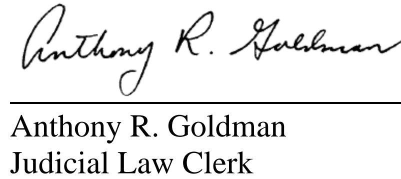
Milton G. Kimpson, Judge
South Carolina Administrative Law Court

December 22, 2021
Columbia, SC

CERTIFICATE OF SERVICE

I, Anthony R. Goldman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).



December 22, 2021
Columbia, SC

Anthony R. Goldman
Judicial Law Clerk