

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. 153304-001-SF

State of Michigan, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 17th day of May 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage for a quantity medical supplies by her health plan. On April 20, 2016, she filed a request with the Director of Insurance and Financial Services for an external review of that denial under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.*

The Petitioner receives health care benefits through a plan sponsored by the State of Michigan (the State Health Plan or the plan), a self-funded government 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 the plan's final adverse determination. BCBSM responded on April 27, 2016, and, after a preliminary review of the information submitted, the Director accepted the request on that date.

Section 2(2) of Act 495, MCL550.1952(2), authorizes the Director to conduct this external review as through the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL550.1901 *et seq.*

The issue in this review can be decided by a contractual analysis. The Director 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

The Petitioner's health care benefits described in a document called *Your Benefit Guide - State Health Plan PPO Medicare-Eligible Retirees* (the benefit guide).

The Petitioner has a neurogenic bladder and no bowel control, dysfunctions caused by nerves damaged during surgery, and she uses incontinence garments to manage her urinary and fecal incontinence.

Beginning in 2015, the plan limited the quantity of incontinence garments to 200 units per month, denying coverage for anything over that amount. The Petitioner, who uses more than 200 units per month, appealed the plan's denial through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 17, 2016, upholding the plan's decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is the plan required to cover incontinence garments in excess of 200 per month?

IV. ANALYSIS

Petitioner's Argument

On the external review request form, the Petitioner wrote:

I have nerve damage and no control of bladder or bowel. I have been receiving incontinence supplies paid for through [the plan] for many years. Last year I was informed the insurance would no longer pay for excess of 200 units per month. I now have a statement from the DME company . . . stating I owe \$865. I wasn't informed of that limitation until after the fact.

In an earlier undated letter to the plan administrator, the Petitioner wrote:

I've been receiving incontinence supplies for 9-10 yrs because of three back surgeries for a tumor that was a form of Spina Bifida with no open spine. It's caused severe nerve damage from my waist down. I have no bladder or bowel control & use a walker. My supplies have been covered, now on this recent statement I owe \$865.25. After all this time I was told the reason was I was only allowed 200 units. I just found out in December 2015. The dates not covered are March 17, May 6, June 3, July 7, Aug 17, Sept 25 of 2015.

Blue Cross said it was their fault because my orders were keyed in wrong. I'm hoping this bill can be adjusted. Also I was told you've had problems with [the medical supply vendor] before so I've changed suppliers on your recommenda-

tion. . . . I'll be receiving 204 units & hope it will be covered & I can make them last a month.

The Plan's Argument

In the final adverse determination, BCBSM's representative explained the plan's decision to the Petitioner:

Service Dates: March 17, 2015; May 6, 2015; June 3, 2015; July 7, 2015;
 August 17, 2015; September 25, 2015

. . . . After careful review, I confirmed the claims processed correctly. According to the terms of your coverage, there is a quantity limit of 200 units per month for the medical supplies (incontinence garments) you received. For the above-referenced service dates, you received the medical supplies after you had reached your benefit maximum and also before your benefit maximum renewed. Therefore, the medical supplies that exceeded your benefit maximum are not eligible for payment. You remain responsible for the non-covered charges totaling \$865.25. . . .

You are covered by the State of Michigan Retiree State Health Plan, PPO Medicare. Page 12 of *Your Benefit Guide State Health Plan PPO for Medicare-Eligible Retirees*, explains that your Plan covers select medical supplies, which includes incontinence garments, when provided by a participating provider. However, these medical supplies are subject to benefit limitations and restrictions.

On the above-referenced service dates, [the medical supply vendor] submitted claims for procedure code A4520 (incontinence garment). According to the *Benefit Package Report* (BPR), which is an online tool used by BCBSM to house procedure-specific group benefit information, procedure code A4520 is payable up to **200 units per month**.

For the medical supplies received on March 17, May 6, July 7, August 17, and September 25, 2015, BCBSM appropriately approved and paid for 200 units for each month (30 days). However, you received a total number of units that exceeded the maximum amount approved under your Plan. Therefore, you remain responsible for the additional non-covered supplies.

On June 3, 2015, you purchased the medical supplies before they were eligible for payment. Because we paid for 200 units purchased on May 6, 2015, additional incontinence garments were not eligible for payment for the rest of the month, which is the next 30 days from the purchase date. Your next purchase was on June 3, 2015, which is within 30 days of the purchase date. Therefore, no payment is warranted from BCBSM.

For future reference, you must wait one month, which is 30 days from your purchase date, before the benefit renews. On day 31, your benefit renews.

Therefore, if you receive 200 incontinence garments on May 6, 2015, the garments will not be eligible for payment before June 6, 2015.

In your appeal letter and during your managerial-level conference, you stated that you required more than the 200 units your coverage provides. To ensure all consideration was given to your appeal, an associate medical director, a board-certified D.O. in Internal Medicine, reviewed your claims, your appeal, and your health care plan benefits for BCBSM. Our medical consultant determined:

According to Blue Cross Blue Shield of Michigan medical policy "Durable Medical Equipment" (DME) items must be medically necessary and not for hygienic purposes. This is consistent with Medicare DME policy, on which BCBSM DME policy is based. The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) identifies incontinent pads as not payable, as they are considered a hygienic item. Since the enclosed documentation does not support a medical need for incontinence garments above the quantity maximum for this group, we are unable to approve this request.

I understand that the outcome of my review is not favorable to you. However, please be assured that all consideration has been given. BCBSM is required to administer benefits based on the terms of your contract, and I am unable to make an exception on your behalf.

Director's Review

The plan covers medical supplies.¹ However, the "Benefit Package Report" (BPR) for the plan further explains that, beginning in 2015, coverage for incontinence garments of any type (HCPCS code A4520) is limited to a maximum of 200 units per month; there is no exception for medical necessity. There is nothing to prevent the State Health Plan from establishing quantity limits on medical supply items such as incontinence garments. Therefore, the Director upholds the plan's decision to cover only 200 units of incontinence garments "per month."

But the Director disagrees with the plan's decision to deny all coverage for the incontinence garments ordered on June 3, 2015. The plan's final adverse determination justified the denial this way:

Because we paid for 200 units purchased on May 6, 2015, additional incontinence garments were not eligible for payment for the rest of the month, which is the next 30 days from the purchase date. Your next purchase was on June 3, 2015, which is within 30 days of the purchase date. Therefore, no payment is warranted from BCBSM.

¹ See benefit guide under the heading "Durable medical equipment; prosthetic and orthotic, and medical supplies" (p. 12).

The BPR says: "Units Allowed Per Individual: per 1 Month Less or equal to 200 units per Month(s)." It does not say, as BCBSM said in the plan's final adverse determination, that the Petitioner is limited to 200 units in any 30-day period. The Director concludes that the Petitioner is eligible to have coverage for not more than 200 units in any calendar month. Therefore, the plan must cover the June 3, 2015, order up to 200 units.

V. ORDER

The Director upholds the plan's final adverse determination of February 17, 2016, insofar as it limits incontinence garment units to not more than 200 in a calendar month.

The final adverse determination is modified to order the plan to immediately cover 200 units of incontinence garments for the month of June 2015. BCBSM shall, within seven days of providing that coverage, furnish the Director with proof that the plan has implemented 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 sixty 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 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