STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of Insurance and Financial Services

In the matter of:

[redacted]
Petitioner

v **File No. 151853-001-SF**

State of Michigan, Plan Sponsor
and
Blue Cross Blue Shield of Michigan, Plan Administrator
Respondents

Issued and entered
this 19th day of February 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 29, 2016, [redacted], authorized representative of her son [redacted] (Petitioner), filed a request for external review with the Department of Insurance and Financial Services. The request for review concerns a denial of coverage issued by Blue Cross Blue Shield of Michigan (BCBSM) for medical supplies. BCBSM is the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The benefits are described in the State of Michigan's *Your Benefit Guide.*

The request for external review was filed under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952) The Petitioner's health benefit plan is such a governmental self-funded plan.

On February 5, 2016, after a preliminary review of the information submitted, the Director accepted the request for review. The Director notified BCBSM of the appeal and asked it to provide the information used to make its final adverse determination. BCBSM furnished its response on February 15, 2016.

The issue in this external 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, who is [redacted] years old, is severely developmentally disabled (autism, focal seizures, static encephalopathy and tuberous sclerosis) and requires incontinence supplies. Beginning on March 4, 2015, the benefit plan was changed to restrict medical supplies for incontinence. Effective on that date coverage for diapers was limited to 200 per month and coverage for pads was eliminated. The Petitioner uses approximately 250 to 300 diapers per month and a similar number of pads.

The Petitioner, through his authorized representative, appealed BCBSM's failure to cover the requested quantity of diapers and pads. BCBSM held a managerial-level conference and issued a final adverse determination dated January 6, 2016, upholding its decision. The Petitioner now seeks the Director's review of that adverse determination.

III. Issue

Is BCBSM required to pay for an additional 64 diapers per month in addition to the pads requested by the Petitioner for the period between March 3 and November 6, 2015?

IV. Analysis

<u>BCBSM's Argument</u>

In the final adverse determination BCBSM wrote:

> This letter will inform you of the outcome of the appeal you filed on behalf of your son...and the managerial-level conference conducted on December 15, 2015. The purpose of the conference was to discuss the quantity of incontinence supplies...permitted per member per month from March 3 through November 6, 2015....
>
> [Petitioner's] plan benefit for incontinence supplies is 200 units per member per month....
>
> In an effort to give your appeal every consideration we had a board-certified M.D. in Internal Medicine review the materials. After review, our medical consultant determined that:
>
>> According to BCBSM Medical Policy "Durable Medical Equipment" items must be medically necessary and not for hygienic purposes. In addition the Centers for Medicare & Medicaid Services (CMS National Coverage Determination (NCD) identify incontinence pads as not payable

> as they are considered a hygienic item. The documentation provided does not support a medical need for incontinence garments above the group quantity maximum. As a result, payment is not available for the non-covered services.

Matthew is an eligible dependent covered under the State Health Plan PPO (SHP PPO). As explained on page 52 of *Your Benefit Guide*, covered services are services, treatments or supplies identified as payable under the SHP PPO. In addition, covered services must be medically necessary to be payable, unless otherwise specified. On page 55 it defines medically necessary as health care services or supplies that are needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and meet accepted standards of medicine.

On page 13 of *Your Benefit Guide* it states your plan covers durable medical equipment, prosthetic and orthotic and medical supplies. The BCBSM Benefit Package Report for your group explains that procedure code A4520 allows 200 units per member per month. As a result, we are unable to approve payment for units receive above your group's quantity limit.

Petitioner's Argument

In a letter dated January 19, 2016 accompanying his request for an external review, the Petitioner's mother wrote:

> I have a severely developmentally disabled son who is now [redacted] years old... I have been receiving incontinence products for him for about 13 years. The amount of product I was able to receive was determined by the doctor's prescription-the most recent prescription from last year was 312 units....
>
> In 2015, BCBS took over administering incontinence supplies and limited the monthly quantity to 200 units. I was not made aware of this and continued to order the roughly 264 units of supplies I have been ordering for years. The supplies I ordered were briefs (diapers) and diaper liners.
>
> * * *
>
> There had never been a quantity limitations prior to 2015. The quantity was limited by the doctor's prescription. The incontinence pads i.e. diaper liners, have been covered all along....
>
> I also contend that 200 units a month is simply not sufficient. That equates to six briefs a day. I am not sure what criteria they are using for a determination of a person only going to the bathroom six times a day. Someone who is incontinent cannot control that, hence they are incontinent. I am not sure how to prove a medical necessity for more than six briefs a day. If my child were in a facility – group home, nursing home, they would be required to check for soiled diapers every 2 hours.
>
> * * *
>
> In summary, the pads were covered for years, the quantity was higher. Now the pads are a non-covered hygiene item and the diaper quantity is limited to 200 monthly pieces. BCBS did rule to go back and pay the provider for up to the 200 quantity limit, but not the overage of 64 pieces a month. I believe they should pay

> for all the claims as they were for over a decade. Also, I request an increase in the monthly limit.

Director's Review

The Petitioner is challenging coverage decisions for two different types of disposable medical supplies for incontinence: diapers and pads. In her appeal, the Petitioner's mother challenges BCBSM's limitation of diapers to 200 per month and BCBSM's denial of any coverage for disposable liners. While both items were covered benefits in the past, the plan sponsor (the State of Michigan) is free to establish restrictions on the quantity of such items that will be covered and whether a particular medical supply will be covered at all.

The Petitioner's argument is that, because the requested items were covered in the past, they should continue to be covered. As the sponsor of a self-funded benefit plan, the State of Michigan has few restrictions on the benefits it will cover. In this case, the State of Michigan, effective on March 4, 2015, limited the quantity of diapers covered per month and eliminated coverage for bed pads. These restrictions may be imposed even when the items are medically necessary.

Because there are no quantities of medical supplies which must be covered under the terms of the *Benefit Guide*, the Director finds that the State of Michigan is not required to continue to provide the coverage it had provided in the past.

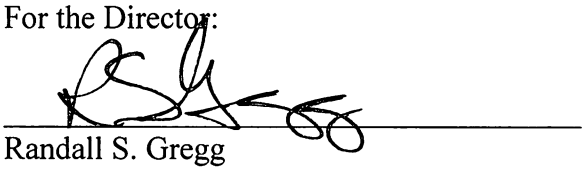
V. ORDER

The Director upholds BCBSM's final adverse determination of January 6, 2016.

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