

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 101651-001

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this ____ day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 25, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on December 4, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on December 15, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Nongroup Comprehensive Health Care Benefits Certificate - Option E* (the certificate). 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

The Petitioner receives chemotherapy for the treatment of cancer. Every few weeks she went to her oncologist's office where she was supplied with an ambulatory infusion pump containing a solution of saline and the chemotherapeutic agent. The physician connected the pump to the Petitioner and it provided a 24-hour infusion. At the conclusion of the infusion, the Petitioner disconnected the pump and sent it back to the oncologist's office.

BCBSM reimbursed the physician for the chemotherapeutic agent and the physician's services. However, BCBSM did not cover the charge for the pump (\$700.00 for each date of service).

The Petitioner appealed BCBSM's denial of the pump charges for March 25, April 25, May 25, and June 25, 2008. BCBSM held a managerial-level conference on September 15, 2008, and issued a final adverse determination dated October 3, 2008.

III ISSUE

Did BCBSM correctly deny coverage for the charge for the ambulatory infusion pump related to Petitioner's chemotherapy?

IV ANALYSIS

Petitioner's Argument

The Petitioner believes that BCBSM has wrongly denied coverage for an ambulatory infusion pump essential to chemotherapy treatment that was prescribed by her doctor. BCBSM indicates that the pump is durable medical equipment (DME) and DME is not a covered benefit under the Petitioner's certificate. However, the Petitioner says DME is covered in some sections of the certificate. Moreover, the Petitioner can find nothing in the contract that excludes ambulatory infusion pumps.

The Petitioner also points to language in the physician services section of the certificate that

indicates the following: “Chemotherapeutic drugs and services required for the treatment of malignant diseases are payable.” The Petitioner believes this language indicates very broad and inclusive coverage for chemotherapy treatment.

The Petitioner says her prescribed treatment is not possible without the pump. She argues that the ambulatory infusion pump used in her chemotherapy is a covered benefit under her certificate.

BCBSM’s Argument

In its final adverse determination, BCBSM said that the pump was considered to be DME and that the Petitioner’s certificate does not cover DME. BCBSM said it would allow benefits for the maintenance of a pump but not for the pump itself.

BCBSM further said that while chemotherapy is covered in Section 3 of the certificate under “Coverage for Physician and Other Professional Provider Services” (including the chemotherapeutic drugs and physician services needed to administer the drugs), nothing in the certificate indicates that the rental or purchase of a pump is covered. BCBSM says the maintenance of an ambulatory infusion pump used in chemotherapy is covered in the event the pump is purchased or rented for long-term use. However, the Petitioner has not purchased the pump.

BCBSM acknowledges that DME is provided for use in a hospital, an end stage renal disease facility, or a hospice, and for home infusion therapy services. But it is BCBSM’s position that an ambulatory infusion pump is not a covered DME benefit under the certificate. The certificate says that only services that are listed in the certificate as being payable are covered. Since the ambulatory infusion pump such used by the Petitioner is not listed as payable, it is excluded from coverage.

Commissioner’s Review

BCBSM is correct that DME is very limited under the Petitioner’s nongroup certificate. However, chemotherapy is a covered benefit. The certificate says:

We pay for chemotherapeutic drugs that are:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program
- Approved by the Food and Drug Administration

* * *

We also pay for:

- Physician services to administer the chemotherapy drug, **except** those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
 - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
 - Drugs used to enhance chemotherapeutic drugs
 - Drugs to prevent or treat the side effects of chemotherapy treatment
- Administration sets, refills and maintenance of implantable or portable pumps and ports [Underling added]

The certificate's provision implements Section 416a of the Nonprofit Health Care Corporation Reform Act (MCL 550.1416a). That section says:

A health care corporation shall provide coverage in each group and nongroup certificate for a federal food and drug administration approved drug used in antineoplastic¹ therapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

- (a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.
- (b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.
- (c) The drug is used as part of an antineoplastic drug regimen.

¹ A neoplasm is a mass of tissue that results from the abnormal proliferation of cells. Malignant neoplasms are commonly called cancer.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications. [Underling added]

Contractual and statutory provisions, read together, require BCBSM to cover medically necessary chemotherapy drugs that are administered in a medically-approved manner at reasonable cost.

There is no dispute here that the chemotherapy was ordered by a physician and provided as part of a chemotherapy program. BCBSM denied coverage for the Petitioner's ambulatory infusion pump on the basis that it was DME and therefore not a benefit under the certificate. BCBSM did not argue that the ambulatory infusion pump was not a medically-approved manner for administering chemotherapy, nor did it argue that the use of an ambulatory infusion pump resulted in an unreasonable cost. The Commissioner concludes, absent any contrary information, that the Petitioner's use of the ambulatory infusion pump is therefore a covered benefit under the certificate and Section 416a.

The Commissioner finds that BCBSM incorrectly applied the provisions of the Petitioner's certificate and state law.

V ORDER

BCBSM's final adverse determination of October 3, 2008, is reversed. BCBSM is required to cover the Petitioner's use of the ambulatory infusion pump as a medically-approved manner for administering her chemotherapy.

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.