

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

File No. 115786-001

v

Health Alliance Plan of Michigan
Respondent

Issued and entered
this _19th_ day of May 2011
by R. Kevin Clinton
Commissioner

ORDER

I

XXXXX (Petitioner), born XXXXX, is a member of Health Alliance Plan of Michigan (HAP) as an eligible dependent under his father's coverage. His benefits and rights are defined in HAP's HMO Subscriber Contract (the contract).

In 2006 the Petitioner was diagnosed with keratoconus, a degenerative disease of the cornea where the shape of the cornea slowly changes from the normal round shape to a cone shape. He was fitted with rigid gas permeable contact lenses in February 2007 and again in 2009 and 2010. The Petitioner sought coverage from HAP for the contact lenses in 2010 but the request was denied on the basis that they are excluded under the contract.

On August 20, 2010, XXXXX, mother of the minor Petitioner, filed on his behalf a request for an external review of that denial with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

The Commissioner notified HAP of the external review and requested the information it used in making its adverse determination. The information was received on August 26, 2010. The Commissioner reviewed the information that was submitted by both parties and accepted the request for external review on August 27, 2010.

When the Commissioner receives a request for an external review under PRIRA, he must complete a "preliminary" review of the request within five days after receiving it and decide whether or not to accept it. MCL 550.1911(2). Sometimes, as in this case, a more exhaustive subsequent examination of the record leads to a different conclusion than the initial decision to accept. After further review, the Commissioner concludes that the Petitioner may not seek an external review of HAP's denial of coverage for his gas permeable contact lenses.

II

HAP is required by law to establish an internal grievance process to provide a way for its members to resolve disputes about benefits, policies, services, etc.¹ HAP's grievance procedure was approved by the Commissioner in 2006 and is on file in the Office of Financial and Insurance Regulation.

HAP's grievance process has two steps. After completing the level 1 review, the member receives a written determination reflecting HAP's decision on the grievance. The member then has 60 days from the date of that written determination to proceed to level 2. HAP's level 1 determination was dated May 24, 2010, and told the Petitioner:

If you remain dissatisfied with our decision and wish to pursue this matter further; you may proceed to the second level of the grievance process. A detailed letter must be submitted within sixty (60) days from the date of this letter explaining why you feel our position should change.

The Petitioner subsequently submitted a request (dated July 20, 2010) to proceed to level 2. In an August 2, 2010, letter to the Petitioner, HAP declined to allow him to go to level 2 because his request was not timely received. HAP's level 1 determination was dated May 24,

1. See Section 2213 of the Insurance Code of 1956, MCL 500.2213.

2010. HAP said the Petitioner's request to proceed to level 2 was postmarked July 26, 2010, and received by HAP on July 29, 2010.² HAP said, "Both of these dates were past the 60 day filing limitation."³ Thus, the Petitioner failed to exhaust HAP's internal grievance process.

The internal formal grievance process is intended to ensure that complaints are investigated and it offers HAP members the right to appear at a managerial-level conference to present information about the grievance. The internal grievance process affords HAP the opportunity to review its determinations in light of the information presented by the member. At the conclusion of the process, HAP must provide the member a written statement, in plain English, of reasons for its adverse determination. The internal grievance process serves to narrow and sharpen the issues before the Petitioner seeks an external review with the Commissioner under PRIRA.

PRIRA clearly contemplates that the Petitioner will engage in and complete the internal grievance process before seeking an external review. In order to receive an external review under PRIRA, the Petitioner must have "exhausted" HAP's internal grievance process. This requirement is found in Section 11(2) of PRIRA, MCL 550.1911(2):

(2) Not later than 5 business days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine all of the following:

* * *

(c) Whether the covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process.

Further, Section 7(2) of PRIRA, MCL 550.1907(2) also says:

Except as provided in subsection (3)(a), a request for an external review . . . shall not be made until the covered person has exhausted the health carrier's internal grievance process provided for by law.

2. A copy of the Petitioner's envelope postmarked July 26, 2010, and his request to proceed to level 2 date stamped July 29, 2010, part of the record.

3. Sixty days from May 24, 2010, is Friday, July 23, 2010.

Section 7(3)(a)(ii), MCL 550.1907(3)(a)(ii), does provide for an exception to the exhaustion requirement:

The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within the required time and without the covered person or the covered person's authorized representative requesting or agreeing to a delay, the covered person or the covered person's authorized representative may file a request for external review under section 9 and shall be considered to have exhausted the health carrier's internal grievance process. . . .

However, this exception does not apply in this case because HAP did issue a level 1 written determination within 30 days of receiving the Petitioner's level 1 grievance request.⁴

The Commissioner concludes that the Petitioner did not exhaust HAP's internal grievance process because he did not timely respond to HAP's written determination of May 24, 2010, and therefore forfeited his right to an external review under PRIRA.

III

HAP's August 2, 2010, letter to the Petitioner told him:

Since you have exceeded your time to pursue this case through HAP's grievance process, you may now proceed to the external independent review under the Patient's Right to Independent Review Act. If you wish to pursue this avenue, you must submit the enclosed Health Care Request for External Review form within sixty (60) days....

When the Petitioner filed his request for external review with the Commissioner on August 20, 2010, it is doubtful that he was aware that exhaustion of HAP's internal grievance process was a prerequisite for receiving an external review; he was expecting a review on the merits. Yet PRIRA requires the Commissioner to determine if the exhaustion requirement has

4. Section 2213(k) of the Insurance Code requires an insurer to make a final determination in writing not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The 35 calendar day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer has not received requested information from a health care facility or health professional. The Petitioner initiated the level 1 grievance on May 14, 2010, and HAP made its determination 10 days later on May 24, 2010.

been met. Based on the information in the record, the Commissioner concluded that it had not been met and therefore he has no jurisdiction to review the Petitioner's case.

Nevertheless, even if the Petitioner had exhausted HAP's internal grievance and his request for external review had been accepted, the Commissioner, after reviewing the entire record, would have concluded that HAP was correct when it denied coverage for the Petitioner's contact lenses. The Commissioner's reasoning follows.

IV

The Petitioner's optometrist prescribed gas permeable contact lenses to treat his keratoconus. According to the optometrist, the Petitioner's corneal health "remains stable with the use of the contact lenses." The Petitioner purchased lenses on March 9, 2010, at a cost of \$190.00. He is seeking reimbursement for those contact lenses and coverage for subsequent lenses.

The Petitioner believes the lenses should be covered by his medical insurance because keratoconus is a medical condition that just happens to affect the eyes. The Petitioner also argues that the lenses should be provided as a "durable medical device" (i.e., durable medical equipment or DME).

HAP declined to cover the contact lenses, saying they are not a covered benefit under the terms of the Petitioner's contract. The contract contains this exclusion (pp. 13, 15):

Section 5—EXCLUSION AND LIMITATIONS

The following are not covered under this Contract:

5.1 Non-Covered Services

* * *

(f) Eye Care and Vision Services

- (1) Eyeglasses and contact lenses.
- (2) Eye examinations for the purpose of prescribing or fitting contact lenses.
- (3) Surgery to correct refractive error including but not limited to Lasik, Radial Keratotomy and Photorefractive Keratectomy.

The contact lenses would be covered if the contract had been amended by HAP's "Vision Hardware Benefit Rider" (the vision rider).⁵ In its May 24, 2010, adverse determination, HAP told the Petitioner:

Contact lenses are lenses placed directly on the eye to correct deficiencies in vision and HAP does provide coverage for gas permeable contact lenses. However, contacts, whether voluntary or medically necessary, for members without the vision rider are not covered according to the HAP Subscriber Contract.

HAP's medical policy on contact lenses also explains (p. 3) that contact lenses are not covered without the vision rider:

EXCLUSIONS

1. Contacts, whether voluntary or medically necessary, for Members without the Vision Rider are not covered according to the HAP/AHL Subscriber Contract.

HAP says the Petitioner does not have the vision rider as part of his coverage and therefore its decision to deny reimbursement and future coverage for gas permeable lenses is consistent with the terms of the contract.

The Commissioner believes that HAP is correct: without the vision rider, contact lenses are specifically excluded as a benefit under the contract.

Michigan law requires health maintenance organizations like HAP to cover "basic health services." MCL 500.3519(3). The list of basic health services, however, does not include vision hardware. MCL 500.3501. As a result, HAP is not obligated to provide vision hardware as a covered benefit. It does offer vision hardware through a rider but the Petitioner does not have the vision rider as part of his coverage.

The Commissioner would also reject the Petitioner's argument that the lenses should be covered as DME because DME, like vision hardware, is not a basic health service and HAP is not required to provide it. DME is specifically excluded under the contract (pp. 13, 15):

5. The rider provides coverage for vision "hardware," i.e., lenses (including contact lenses) and frames.

Section 5—EXCLUSION AND LIMITATIONS

The following are not covered under this Contract:

5.1 Non-Covered Services

* * *

(h) Medical Devices and Equipment, including:

- (1) Durable Medical Equipment (DME), including Medically Necessary equipment, such as crutches and wheelchairs, that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed or used by a person in the absence of illness or injury.
- (2) Disposable medical supplies, such as dressings and support garments.
- (3) Prosthetic appliances, including devices or equipment, such as prosthetic limbs, used to replace a missing or malfunctioning body part.
- (4) Orthopedic devices, including rigid or semi-rigid devices, such as special shoes and custom-molded shoe inserts, used to support or immobilize a weak or injured body part.
- (5) Hearing aids.

The Commissioner would have concluded that HAP's denial of coverage for the gas permeable contact lenses was in accord with the terms of the contract.

IV

The Commissioner dismisses the Petitioner's request for external review under the Patient's Right to Independent Review Act that was accepted on August 27, 2010.

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

R. Kevin Clinton
Commissioner