

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

XXXXXX

Petitioner

v

File No. 119932-001-SF

Blue Cross Blue Shield of Michigan

Respondent

Issued and entered
this 20th day of August 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 8, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The case was accepted for review on March 15, 2011.

The Petitioner receives health care benefits through XXXXX, a self-funded plan administered by Blue Cross and Blue Shield of Michigan (BCBSM).

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

Because it involved medical issues, the case was assigned to an independent review organization which provided its analysis and recommendations on March 28, 2011.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the BCBSM *Community Blue Group Benefits Certificate* (the certificate).

The Petitioner has been diagnosed with spastic cerebral palsy. On August 19, 2010, she ordered a "half power" standing wheelchair from the Standing Company. A standing wheelchair allows someone who is normally confined to a seated position in a traditional wheelchair to stand up. The Petitioner's half powered wheelchair has powered mobility but a manually operated standing mechanism.

When BCBSM became aware that the device was a standing wheelchair, it denied coverage. The Petitioner appealed the denial through BCBSM's internal grievance process. After a managerial-level conference on December 28, 2010, BCBSM upheld its decision and issued a final adverse determination dated January 18, 2011.

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's standing wheelchair?

IV. ANALYSIS

Petitioner's Argument

The Petitioner is unable to stand on her own without assistance. Her physical therapist informed her of the health benefits that a standing wheelchair would bring to her daily living. The Petitioner argues that this chair is not a convenience, but is a necessity for her health and well-being. She provided a letter from her doctor indicating the medical need for a standing wheelchair.

The Petitioner believes that her standing wheelchair is a covered benefit under her certificate and BCBSM is required to pre-authorize and pay for it.

BCBSM's Argument

BCBSM states that under the terms of the certificate, services must be medically necessary to be covered. BCBSM's medical consultants reviewed the documentation and determined that the standing wheelchair and accessories were not a covered benefit.

BCBSM's review examined whether the standing wheelchair would allow the Petitioner to optimize her lower extremity and spinal neuro-skeletal development. The BCBSM consultants determined that while the Petitioner might benefit from the standing wheelchair,

those are benefits could apply to all patients confined to wheelchairs. Given the Petitioner's age, the BCBSM consultants further determined that special medical necessity growth and development needs were not demonstrated in the medical documentation provided.

BCBSM submits that the denial of the standing wheelchair was correct and according to the terms of the Petitioner's certificate.

Commissioner's Review

The certificate (p. 7.14) requires that a service must be medically necessary to be covered. "Medical necessity," as it relates to other than professional services or hospitals, is defined on p. 7.15 of the certificate:

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

Durable medical equipment (DME) is a covered benefit under the certificate. However, certain items of DME are not covered (p. 5.3 of the certificate):

We do not pay for:

* * *

- Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that patients can operate the equipment themselves
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners

The question of whether the Petitioner's standing wheelchair was medically necessary was presented to an independent medical review organization (IRO) for analysis, as required by Section 11(6) of the Patient's Right to Independent Review Act. The IRO reviewer is certified by the American Board of Pediatrics in general pediatrics and pediatric hematology/oncology and is in active practice. The reviewer is also a member of the American Academy of Pediatrics and is published in peer reviewed medical literature. The IRO report included the following:

It is the determination of this reviewer that the Power Standing Wheelchair was considered medically necessary for the treatment of the [Petitioner's] condition.

* * *

This [Petitioner] has a diagnosis of spastic cerebral palsy, and per the clinical documentation provided for review, has some use of her upper extremities to give her the ability to perform certain tasks on her own. However, she does not have the ability to stand at all unassisted. Since the policy previously approved her use of a power wheelchair, and since this item is clearly appropriate for this [Petitioner] who can use the controls herself, this is not the piece of concern. The question here lies in the "standing" portion of the wheelchair, which is manual and will be operated by the enrollee herself. RESNA lists several medical concerns which may benefit from these standing devices. Specific to this [Petitioner] are the functional reach / access to ADLs, passive range of motion (ROM) / contractures, bone mineral density, spasticity, skeletal deformities, and community environments (with her attending school). This is supported by the current medical literature, such as the improvement in vertebral bone mineral density . . . and the help with contracture management. . . .

* * *

. . . [T]he use of this device is in accordance with generally accepted standards of medical practice, appears to be clinically appropriate in terms of its type and considered effective for the [Petitioner's] illness, not primarily for the convenience of anyone, and is not more costly than an alternative option.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO's recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case. The Commissioner accepts the recommendation of the IRO and finds that the standing wheelchair is medically necessary for treatment of the Petitioner's condition and therefore is a covered benefit under the certificate. BCBSM provided no information establishing that this device is not a covered benefit if medically necessary.

V. ORDER

Respondent BCBSM's January 18, 2011, final adverse determination is hereby reversed. BCBSM is required to provide pre-authorization and coverage for the Petitioner's standing wheelchair. Coverage is to be provided within 60 days from the date of this Order with proof of compliance provided to the Commissioner within seven days of compliance.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

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 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