

**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. 151480-001**

**HealthPlus Insurance Company**  
**Respondent**

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**Issued and entered**  
**this ~~22<sup>nd</sup>~~ day of January 2016**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On December 28, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives health care benefits through a group plan that is underwritten by HealthPlus Insurance Company (HealthPlus). The Director notified HealthPlus of the external review request and asked for the information it used to make its final adverse determination. HealthPlus furnished its response on December 28, 2015. After a preliminary review of the information submitted, the Director accepted the request on January 6, 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**

On September 10, 2015, the Petitioner had surgery on her foot and ankle for osteoarthritis. The Petitioner was required to put no weight on her leg for 12 weeks after her surgery. As part of the pre-surgery planning, in July 2015, the Petitioner's physician prescribed a knee walker for use after the surgery. The knee walker is an item of durable medical equipment (DME). Its rental cost is \$60.00 per month. The Petitioner contacted HealthPlus and received approval for the knee walker. The Petitioner received the knee walker on September 2, 2015.

When the claim was submitted, HealthPlus denied coverage. The Petitioner appealed the denial through the HealthPlus internal grievance process. At the conclusion of that process, on October 29,

2015, HealthPlus issued a final adverse determination affirming its coverage denial. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ISSUE

Did HealthPlus correctly deny coverage for the Petitioner's knee walker?

### IV. ANALYSIS

#### Respondent's Argument

In the final adverse determination issued to the Petitioner, HealthPlus stated that its denial of coverage:

is based on your enclosed Schedule of Benefits (SOB); section **Durable Medical Equipment**, which states

*Coverage for Medically Necessary devices or appliances obtained from Preferred Providers (Comfort and convenience equipment, exercise and hygiene equipment, and dental appliances are **not covered**). [Underline added]*

Your enclosed Certificate of Coverage (COC), **Section II – Definitions**, indicates

*(2.47) "Medically Necessary" (or "Medical Necessity") means services or supplies provided to Members that are medically required and appropriate to diagnose or treat a Member's physical or mental condition. Also, such services or supplies must:*

*(2) Not be used primarily for the comfort or convenience of the Member, the Member's family or caregiver, or the Member's treating Physician.*

*[Underline added]*

You indicated that you were advised during a call to HPI in July 2015 that a knee walker would be covered 100%. Customer Service representatives make every effort to provide the most accurate information when members call with benefit inquiries. At the time of your inquiry, you were given correct information. As you indicated, between the time of your inquiry in July to when services were rendered in September, the benefit criteria changed. This is due to, in accordance with your enclosed COC, **Section XVI – General Terms and Conditions**, (16.8) *Policies and Procedures*,

*HPI may unilaterally adopt and change reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Certificate. HPI reserves the right to review services, supplies, products, and procedures for efficacy of use and quality to determine if they should be available to HPI Members.*

A team of HPI clinical staff, which includes a Plan Medical Director, reviewed clinical guidelines for crutch substitutes (knee walkers). It was determined that effective September 1, 2015; HPI's Clinical Policy Guideline would establish Crutch Substitutes to no longer be a covered item. However, for ambulation needs when non-weight bearing is indicated, traditional crutches are available, and are a covered item.

#### Petitioner's Argument

In her request for external review, the Petitioner wrote:

I had orthopedic surgery on September 10, 2015. In July I contacted my insurance carrier, HealthPlus of Michigan to approve my surgery as well as some durable medical equipment I would need to get around. This was a scooter to rest my knee on. My surgery was on my foot and my doctor did not want me to put any pressure on it. HealthPlus assured me as well as my agent that the scooter would be covered as a rental. I picked up the scooter on September 2 before my surgery. Unaware to me and with no communication from HealthPlus they decided not to cover this item as of September 1, 2015. I called them and put in a complaint which they denied. I feel this is unacceptable due to the fact they assured me it was covered. They make it necessary to get advance approval to use approved vendors. I followed their rules. This type of denial should not be allowed. They make a huge point of having things like this approved in advance and then to deny it is simply wrong and misleading. I feel HealthPlus should be forced to reimburse me for the rental of this scooter.

### Director's Review

Provisions in three HealthPlus documents are relevant to this appeal. Those provisions are reprinted below.

The HealthPlus certificate of coverage, on page 25, describes the coverage for durable medical equipment:

#### SECTION VIII – SCHEDULE OF COVERED SERVICES

\* \* \*

##### **8.13 DURABLE MEDICAL EQUIPMENT (“DME”)**

Coverage for Medically Necessary equipment obtained from Preferred Providers including urological and ostomy supplies, and diabetic management supplies if the Member does not have Prescription Drug Coverage.

Members should contact HPI's Customer Service department for more information regarding specific Coverage questions. Prior Authorization from HPI or its designee is required for individual DME items costing three thousand dollars (\$3,000.00) or more. No Coverage for DME obtained from a Non-Preferred Provider.

The Schedule of Benefits, on page 13, provides:

**DURABLE MEDICAL EQUIPMENT (DME)** *Prior Authorization is required for individual DME items costing one thousand five hundred dollars (\$1,500) or more, and for those DME items listed on our website [www.healthplus.org](http://www.healthplus.org). Contact Customer Services at 1-888-212-1512 about mandatory Preferred Providers for supplies for chronic conditions such as diabetes. See the Certificate of Coverage for a complete list of non-covered items.*

The HealthPlus Clinical Policy Guideline titled “Crutch Substitutes” (revised September 1, 2015) states:

#### **I. DEFINITION**

Crutches allow for ambulation needs when non-weight bearing to the lower extremity is indicated. There are a variety of crutches currently available to provide the support needed for non-weight bearing.

More recently two types of alternatives to "traditional" crutches have been available. These crutch substitutes can allow for support of the lower extremities. These types of crutches work by strapping the affected leg to the support frame that transfers the weight from the member's lower leg to their knee or thigh.

## II. POLICY/CRITERIA

Crutch substitutes are not a covered benefit for members when ordered by a physician. Crutch substitutes are considered durable medical equipment.

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## V. PRODUCT LINE COVERAGE

Please reference contract benefit rider, benefit description, Master Plan Document, Evidence of Coverage (EoC) and Certificate of Coverage (CoC) for applicable limits and copayments, including other exceptions and/or exclusions for specific coverage.

If there is a conflict between this medical policy and the individual or group insurance policy document (i.e., certificate), the terms of the individual or group insurance policy will govern, unless specifically noted.

Citing these documents, HealthPlus presented two reasons to justify its denial of coverage: 1) the knee walker was excluded from coverage under its Clinical Policy Guideline, and, 2) the knee walker was not medically necessary because it was "used primarily for the comfort or convenience of the Member." Each argument is addressed below.

### Clinical Policy Guideline

The Clinical Policy Guideline does exclude knee walkers from coverage. However there are two reasons why the Guideline should not apply to the present case. First, HealthPlus had approved coverage for the knee walker before the Guideline had been revised to exclude coverage. HealthPlus did not make any effort to inform the Petitioner, or, apparently, any other member, that the policy had been changed. There is no indication that the revised policy was disseminated to HealthPlus members. Under these circumstances, HealthPlus's approval should be considered binding.

The Guideline itself states that it will not be used to determine coverage if it is in conflict with a HealthPlus certificate of coverage. The Petitioner's certificate of coverage simply states that coverage is provided for DME so long as more expensive DME items are approved in advance by HealthPlus.<sup>1</sup> The knee walker does not meet the financial threshold where prior approval is required. By obtaining coverage approval from HealthPlus before her surgery, the Petitioner actually exceeded the requirements of her benefit plan. The Schedule of Benefits indicates that DME must be obtained from a preferred provider. It appears from the materials submitted that the provider the Petitioner used was a HealthPlus

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1. This threshold is reported in the certificate of coverage as \$3,000.00 and in the schedule of benefits as \$1,500.00. The total cost of renting the knee walker for the 3 months prescribed by the Petitioner's doctor is \$180.00.

preferred provider. The certificate of coverage and schedule of benefits place no other restrictions on obtaining DME.

The certificate of coverage, with its broad standards for DME coverage, conflicts with the restriction of the Guideline. In that circumstance, the certificate of coverage supersedes the Guideline.

Comfort or Convenience

HealthPlus argues, correctly, that DME items used solely for a member's comfort or convenience are not medically necessary and are, for that reason, not medically necessary. However, the knee walker was not used solely for comfort or convenience. It was used primarily to prevent weight bearing on the Petitioner's leg. The knee walker may have also been comfortable or convenient, but that was not its primary function. For that reason, the Director finds that denial of coverage on the basis of that exclusion is not applicable to the Petitioner's circumstance.

The Director therefore finds that HealthPlus Insurance Company's denial of coverage for the Petitioner's rental of a knee walker is not consistent with the terms of the Petitioner's benefit plan.

**V. ORDER**

The Director reverses HealthPlus' final adverse determination of October 29, 2015. HealthPlus shall immediately provide coverage for the Petitioner's rental of the knee walker up to the three months stated in her prescription. HealthPlus shall, within seven days of providing coverage, furnish to the Director proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding its implementation the Department of Insurance and Financial Services, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. 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 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:



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Randall S. Gregg  
Special Deputy Director