

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. 150378-001-SF

Central Michigan University, Plan Sponsor

and

Blue Cross Blue Shield of Michigan, Plan Administrator  
Respondents

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Issued and entered  
this 2<sup>nd</sup> day of December 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On October 15, 2015, ██████████ (Petitioner) filed a request for external review with the Department of Insurance and Financial Services, appealing a claim denial issued by Blue Cross Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan which is sponsored by Central Michigan University. 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 persons 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 550.1901, *et seq.*) The Petitioner's benefit plan is such a governmental self-funded plan. The plan's benefits are defined in BCBSM's *Community Blue Group Benefits Certificate ASC*.

The Director accepted the Petitioner's request for review on October 22, 2015. The Director notified BCBSM of the external review request and asked for the information used to make its final adverse determination. The Director received BCBSM's response on October 30, 2015.

This case was originally accepted for review as a contractual dispute. Later, it was determined that the case required a medical review. To address the medical issues in the case, the Director assigned the matter to an independent medical review organization which provided its analysis and recommendation on November 18, 2015.

## II. FACTUAL BACKGROUND

The Petitioner had her pancreas removed in 2014 and now has diabetes. She uses an insulin pump. Her doctor has ordered monthly office visits for glucose testing. BCBSM provided coverage for two visits but denied coverage for any additional visits ruling that the Petitioner's coverage limits coverage to two visits per calendar year. The charge for each visit is \$76.00.

The Petitioner appealed BCBSM's denial of coverage. BCBSM held a managerial-level conference on September 15, 2015 and issued a final determination on September 25, 2015, affirming its denial. The Petitioner now seeks the Director's review of the denial.

## III. ISSUE

May BCBSM limit the Petitioner's glucose monitoring tests and office visits to two per year?

## IV. ANALYSIS

### BCBSM's Argument

In its final adverse determination BCBSM wrote:

You are covered under the *Community Blue Group Benefits Certificate ASC*. As explained under the *Benefit Package Report (BPR)* for your health care plan, which is an online tool used by BCBSM to store specific benefit information for your group, procedure code 95251 is only payable for two visits per calendar year.

Prior to the last service on August 5, 2015 for procedure code 95251, you had already exhausted your benefit maximum of two visits per calendar year. According to BCBSM records, the dates of service you utilized these two visits were on March 25, 2015 and May 26, 2015. Further, office visits are subject to a \$10.00 copayment according to the contractual guidelines of your health care coverage, and was included in your total charges for each visit in question.

### Petitioner's Argument

In the request for an external review, the Petitioner wrote:

I am appealing decision made by BCBS. The statute need to be updated. I have had [my] pancreas removed and need this procedure more than 2 times a year to correctly keep my diabetes controlled. Without this doctors can't monitor the insulin pump's effectiveness or be sure that my dosages are correct.

In a letter dated August 27, 2015, the Petitioner's physician explains why the diagnostic services are necessary:

This patient will need regular readings evaluated from personal sensor and insulin pump by the doctor who is monitoring her diabetes care. Pt with fluctuating blood sugars and changes to insulin doses with insulin pump require up to monthly checks and sensor and insulin downloads that will be billed. Please cover at minimum 12 sensor readings per year as needed to safely manage her diabetes.

### Director's Review

In support of its denial of coverage, BCBSM cited the following provision in the Petitioner's *Community Blue* certificate (page 31):

#### Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology tests and services needed to diagnose a disease, illness, pregnancy or injury. Services must be provided:

- In a hospital (under the direction of a pathologist employed by the hospital) or
- By the patient's in-network physician or by another physician if your in-network physician refers you to one, or by an in-network laboratory at your in-network physician's direction.
  - Standard office laboratory tests approved by BCBSM performed in an in-network physician's office are payable. Other laboratory tests must be sent to an in-network laboratory....

BCBSM states that the plan's benefits are explained in more detail in a document called the Benefit Package Report, or BPR, an internal BCBSM document which lists benefit-specific information. According to the BPR, benefits for procedure code 95251 are limited to no more than two visits per calendar year.

Procedure code 95251 is "ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report."<sup>1</sup>

The *Community Blue* certificate, on page 63, provides coverage for its "outpatient diabetes management program" and includes this description of coverage:

#### **We pay for:**

Selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O. Refer to Section 7 for the definition of "medically necessary."

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1. This definition is found in the American Medical Association's manual, *Current Procedural Terminology*. The codes in this manual, usually five digit numbers, are commonly referred to as "CPT codes" or "procedure codes" and are used by providers and others to describe medical services when claims are submitted to insurers.

This provision more closely describes the services the Petitioner wants BCBSM to cover than does the provision on page 31 and the related restriction described in the BPR. The question of whether is it medically necessary for Petitioner to have glucose monitoring performed monthly was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6).

The IRO reviewer is a physician in active practice who is board certified in internal medicine and endocrinology and is familiar with the medical management of patients with the Petitioner's condition. The IRO reviewer's report included the following analysis and recommendation:

[T]his case involves a 52 year-old female who has a history of secondary diabetes. At issue in this appeal the request for authorization and coverage of monthly glucose monitoring (CPT code 95251 – ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; physician interpretation and report) for the member.

The member has been seen multiple times per year. There are notations that the continuous glucose monitor and pump settings were adjusted on 9/21/15, 5/26/15, 3/25/15 and 2/19/15. The member began the continuous glucose monitor on 12/20/14. Approximately two weeks later on 1/15/15, there were adjustments made. However...there was no mention of whether the continuous glucose monitor data impacted the decision to adjust settings. The record from 1/15/15 noted that the member checked her blood sugars 4 times per day. However... there is no mention of severe low blood sugars requiring the assistance of others in the records provided for review.

CPT code 95251 is a diagnostic service as it is being used here to help diagnose erratic blood sugars and help with insulin adjustments for the member's insulin pump...[C]ontinuous glucose monitoring is usually used to adjust settings on pumps while the patient is wearing the continuous glucose monitor or at physician visits...[I]t is unusual to have this done every month...[W]hile this member does have a type of diabetes that is typically difficult to control due to pancreatectomy and resulting loss of alpha cells that make glucagon, there is no evidence of severely low blood sugars in the information submitted for review...[W]hile it is reasonable to review the continuous glucose monitor more frequently than 2 times per year in these circumstances, the information provided for review does not support the need for monthly reviews.

Pursuant to the information set forth above and available documentation... monthly glucose monitoring is not medically necessary for diagnosis and treatment of the member's condition, but...quarterly glucose monitoring...is medically necessary for diagnosis and treatment of her condition.

The Director is not required to accept the IRO's recommendation. *Ross v Blue Care Network of Michigan*, 480 Mich 153 (2008). However, the recommendation is afforded deference by the Director. In a decision to uphold or reverse an adverse determination, the Director must cite "the principal reason or reasons why the [Director] did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's recommendation is based on experience, expertise, and professional judgment. Furthermore, it is not contrary to any provision of the certificate of coverage. MCL 550.1911(15). The Director can discern no reason why the IRO's recommendation should be disregarded in the present case.

The Director finds that BCBSM must provide coverage for "services and medical supplies to treat and control diabetes." The Director further finds that the Petitioner's glucose monitoring performed in office visits is medically necessary four times per year.

#### V. ORDER

The Director reverses, in part, BCBSM's final adverse determination of September 25, 2015. BCBSM shall provide to the Petitioner coverage for blood glucose monitoring services on a quarterly basis. BCBSM shall provide coverage for two additional monitoring office visits and tests for the calendar year 2015.

Within seven days of providing coverage, BCBSM shall furnish the Director with proof it has implemented this order.

To enforce this order, the Petitioner may report any complaint regarding the implementation to the Department of Insurance and Financial Services, Health Care Appeals Section, at this toll free number: (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 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. See MCL 550.1915(1). 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