

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. 151764-001-SF

City of Detroit, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 11th day of February 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage by his health plan for a mask and headgear used with a continuous positive airway pressure (CPAP) machine.

On January 19, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under Public Act No. 495 of 2002 (Act 495), MCL 550.1951 *et seq.* On January 26, 2016, after a preliminary review of the information submitted, the Director accepted the Petitioner's request

The Petitioner receives health care benefits through a plan sponsored by the City of Detroit (the plan), a self-funded governmental health plan subject to Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director immediately notified BCBSM of the external review request and asked for the information it used to make the plan's final adverse determination. The Director received BCBSM's response on February 2, 2016.

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

This case presents an issue of contractual interpretation. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent medical review organization.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are described in BCBSM's *Community Blue Group Benefits Certificate ASC*¹ (the certificate).

The Petitioner has sleep apnea and used a CPAP machine. However, he experienced difficulty with the mask and was advised by his physician to acquire a different type.

On June 10, 2015, the Petitioner purchased a mask (procedure code A7030) and a related headgear (procedure code A7035), both items of durable medical equipment (DME). The charge for the mask and headgear was \$450.00. BCBSM, acting for the plan, denied coverage for this equipment.

The Petitioner appealed the denial through the plan's internal grievance process. BCBSM held a managerial-level conference and then issued a final adverse determination dated January 8, 2016, upholding the decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Is the plan required to cover the CPAP mask and headgear the Petitioner purchased on June 10, 2015?

IV. ANALYSIS

Petitioner's Argument

The Petitioner explained his position in an undated letter of appeal to BCBSM, received on December 7, 2015:

I am writing this request due to the fact that [the DME supplier] had charged me full price for my CPAP mask and CPAP head gear. I was advised that I had ordered my mask before I was eligible for a new one, which was 90 days. The reason I took the mask back was because it was leaking. I went to my doctor's office twice, in an attempt to see how to properly fit the mask. They advised me that the mask was not a good style for the amount of air that was pushing through my mask. They also advised me that I was not wearing it improperly, and should get the new style out. They stated that many users with a high pressure output were having success with it. I went to get the new mask in March, and haven't had a problem with any air leakage since. I'm asking you to cover my mask that I was not eligible for the above reasons.

In an email dated February 2, 2016, sent for the external review, the Petitioner further explained:

I wasn't sure if I had in my notes that I was diagnosed with an enlarged heart. My cardiologist . . . advised me that my enlarged heart was a result of my sleep apnea. [The

¹ BCBSM form no. 457F, effective 02/15.

cardiologist] also advised me that using the bi-pap machine would assist me in not doing any additional damage, and possibly correcting the problem. Seeing how the mask I was using was leaking and doing more harm than good it was necessary for me to purchase a mask that would fit properly and work appropriately for the amount of air that was being pushed through the mask. Obviously there were only 2 options; go without a mask till my 90 days were up or 2. Get another mask that worked properly. I did not want my health to deteriorate anymore, so I went for option 2.

BCBSM's Argument

In the final adverse determination, BCBSM told the Petitioner:

. . . After review, I have confirmed that this claim has been processed correctly. On the date of service in question, you had reached your benefit maximum for procedures A7030 and A7035. As a result, you remain responsible for the non-covered charges for the mask (\$336.35) and headgear (\$113.65).

* * *

The supplies and accessories that are covered under your CPAP benefit are payable subject to limitations that are detailed in Blue Cross Blue Shield of Michigan's Benefit Package Report for your group's coverage. Specifically, your CPAP mask (procedure A7030) is payable once, for each member, for each 85-day time period, and your headgear (procedure A7035) is payable once for each member, for each 175-day time period. Because you had previously purchased both items from Oakwood Home Medical Equipment on March 24, 2015, the benefit for your mask did not renew until June 17, 2015, and the benefit for your headgear did not renew until September 15, 2015. Therefore, BCBSM is unable to approve payment for either piece of equipment that you purchased on June 10, 2015.

I understand your concern about the out-of-pocket cost of your equipment. However, BCBSM is required to administer benefits in accordance with the contractual provisions of your group coverage, and I am unable to make an exception on your behalf.

In its February 2, 2016, email sent in response to the external review, BCBSM asserted that the Petitioner was aware the equipment would not be covered:

At the time of the internal review, BCBSM contacted the billing department of the present [DME] provider . . . who state they advised [the Petitioner] that he was still within the 85 day benefit period of the March 2015 claim from Oakland Medical Services, and that the equipment would not be covered before his purchase.

Director's Review

The certificate (p. 35) describes the CPAP therapy benefit:

We pay for:

Continuous Positive Airway Pressure (CPAP)

When prescribed by a physician, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.
- We will pay for the purchase of any related supplies and accessories.

The “related supplies and accessories” are explained in more detail in the Benefit Package Report (BPR), an internal BCBSM document which gives plan-specific information. For the Petitioner’s plan, the BPR says a mask is payable once in an 85-day period and headgear is payable once in a 175-day period.

The record shows that the Petitioner obtained both a mask and headgear on March 24, 2015. Therefore, he was not eligible to obtain a new mask until June 17, 2015, or new headgear until September 15, 2015. There is nothing in the certificate or in state law that would require the plan to cover a new mask or new headgear any sooner, even if the Petitioner was experiencing difficulty with his old mask.

The Director concludes that the Petitioner was not eligible for either a new mask or headgear on June 10, 2015, and the plan’s denial of coverage was correct.

V. ORDER

The Director upholds the plan’s final adverse determination of January 8, 2016.

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 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,



Randall S. Gregg
Special Deputy Director