

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. 153736-001

Blue Cross Blue Shield of Michigan,
Respondent.

Issued and entered
this 17th day of June 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

██████████ (Petitioner) was denied coverage for certain wound care supplies by her health insurance carrier, Blue Cross Blue Shield of Michigan (BCBSM).

On May 18, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of that denial under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Director accepted the request on May 25, 2016.

The Petitioner receives group health care benefits through a plan underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM responded on May 27, 2016.

To address the medical issue in the case, the Director assigned it to an independent medical review organization, which provided its analysis and recommendation on June 8, 2016.

II. FACTUAL BACKGROUND

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

The Petitioner received wound care supplies (procedure code A6550, "wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories") on January 4 and January 20, 2016.

BCBSM says the Petitioner is limited to 15 units of wound care supplies per month. Therefore it covered only 15 of 25 units on January 4, and further denied coverage for additional units on January 20, saying the January 2016 quantity limit had been reached.

The Petitioner appealed BCBSM's decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated April 18, 2016, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage for wound care supplies in January 2016?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination to the Petitioner, BCBSM's representative wrote:

... After review, I have confirmed that the denial of payment for these services is correct. The service reported-procedure code A6550 ... is covered under your health plan. However, your coverage is subject to frequency limitations. Because you had reached your benefit maximum for January, 2016, prior to receiving the services at issue in this appeal, BCBSM cannot offer payment for these supplies, and you remain responsible for the non-covered charges of \$290.03 and \$401.50.

You are covered under the *Community Blue Group Benefits Certificate SG*. On Page 56 of **Section 3: What BCBSM Pays For**, your certificate states that subject to cost-share, BCBSM pay for medically necessary supplies and dressings used for treatment of a specific medical condition. However, medical supplies are covered with limitations. This is supported by *Blue Cross Blue Shield of Michigan's Benefit Package Report* for your group which states your wound care set (procedure A6550) is covered at a quantity of less or equal to 15 units for each individual, each calendar month.

On the first date of service at issue, your provider reported 25 units of service. The services reported on this claim met and exceeded your 15-unit benefit maximum for January, 2016. BCBSM paid for the first 15 units, but units exceeding that threshold denied payment. Payment was also denied for the additional units reported on January 20, 2016. Under the provisions of your group coverage, BCBSM is unable to offer payment for the services that exceeded your benefit maximum.

Petitioner's Argument

In an undated "To Whom It May Concern" letter included with the external review request, the Petitioner explained her argument:

. . . I had a hysterectomy in June 2015. I developed a post-operative infection that was treated through August 2015. It was determined at the end of August that I needed a 2nd surgery to clean out the infected fistula tracks, and to put in a wound vac. I continued with the wound vac therapy until the end of October. The wound began to open up, again developing infections and fistula tracks from the surface of the skin to the abdominal wall. It was determined mid-November that I needed a 3rd surgery. The surgeon explained that I was likely having a reaction to the sutures from the initial surgery in June. She would need to open and clean out the wound, removing the sutures on my abdominal wall, and putting the wound vac back on. The surgery was performed Dec 15th, 2015.

Once the wound vac is on, the dressing and canister for the wound vac need to be changed every 2-3 days. When the dressing is changed, it is necessary to get a good seal for proper closure, or the dressing would have to [be] changed again, taking 1 to 2 sterile dressing kits per change. How long the wound vac stayed on varied by the closure and healing, depending on the doctor's recommendation. The wound vac aids in healing; usually taking 6-8 weeks plus for total healing. My visiting nurse, and wound care would order supplies as needed.

I was not aware my insurance only covered a set number of supplies per month, as I had no issue with ordering supplies the previous months. Only when I received a bill from KCI did I realize the issue. I contacted Blue Cross & Blue Shield of Michigan in February 2016 to find out why I had received a bill from KCI for supplies, when I had been getting them for a month already at that time. I notified them that I was still had the wound vac on, likely needing it for the next several months. Being a medical device, and due to the size of my wound, I needed continued wound vac therapy and thus medical supplies for the wound vac. BCBSM informed me that my maximum number of supplies covered had been reached for January of 2016. If we are only halfway through the month, how can the insurance state they would no longer cover the rest of the needed supplies for the month? I had no control over the length of time needed for wound vac therapy, nor the amount of supplies I would need. It was essential that I would not run out of the needed supplies, or the wound vac would not be able to be used. Due to the size of the wound, other treatments were not an option. I was notified of my coverage (covering 15 units per calendar month), and was told I could appeal their non-coverage decision.

I wrote a letter of appeal to BCBSM explaining my situation, understanding they only covered 15 units for January, and 25 units had been ordered. I talked to a BCBSM representative assigned to my case, informing her of the need at the time for supplies due to my surgery and wound. I explained to her that I understood my plan only covered 15 units per month, but due to the need for wound vac supplies, I was filing an appeal for BCBSM to cover the additional supplies. She informed me that they would decide on my case and I should receive notification within 1 week.

I received a letter of decision from BCBSM around April 20, 2016 stating that according to my plan, insurance would only cover 15 units per month, not 25. I was

responsible for the addition supplies. That's what I was appealing! I told them both in my letter and to the representative that I understood my plan only covered 15 units, but I was appealing that decision due to the wound and necessity of the supplies. I had no control over how long the wound vac needed to be on; that depends on the healing of the wound and the recommendation of the doctor. In January, I was only at the very beginning of my therapy. In fact, I needed the wound vac until the first part of April 2016. According to the denial letter I received from BCBSM I can request an external 3rd party review / appeal. I am also including with this appeal letter a copy of treatment dates from my visiting nurse, and wound care. I have also included a picture of my wound at the time of the denied coverage for supplies. As you can see, it was quite a wound (just as deep as it was big). . . .

Director's Review

The certificate covers medical supplies (p. 56):

We pay for medical supplies and dressings used for the treatment of a specific medical condition. The quantity of medical supplies and dressings must be medically necessary. They include but are not limited to:

- Gauze
- Cotton
- Fabrics
- Plaster and other materials used in dressings and casts

Refer to Section 7 for the definition of "medically necessary."

The certificate defines "medically necessary" in "Section 7: Definitions" (p. 164):

Medically Necessary

A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

- **Medical necessity for payment of services of other providers:**

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.

BCBSM says the *Benefit Package Report* for the Petitioner's plan strictly limits wound care sets to 15 units per month. However, there is nothing in the certificate's description of the medical supplies benefit that would put the Petitioner on notice that some supplies are limited. In fact, the certificate says only that medical supplies must be "medically necessary" and "necessary and appropriate for the patient's condition."

Thus, the question of whether the wound care medical supplies that the Petitioner received in January 2016 were medically necessary to treat her condition 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 physician reviewer is board certified in surgery and critical care, has been in active practice for more than 15 years, and is familiar with the medical management of patients with the Petitioner's condition. The IRO report included the following analysis and recommendation:

Recommended Decision:

The MAXIMUS physician consultant determined that the additional medical supplies (procedure code A6650 (dressing set for negative pressure wound therapy, electric pump, each)) received in January 2016 were medically necessary for treatment of the member's condition.

Rationale:

* * *

The results of the consultant's review indicate that this case involves a 38 year-old female who underwent a hysterectomy in August 2015, which resulted in her having an open wound. At issue in this appeal is whether the additional medical supplies (procedure code A6550 (dressing set for negative pressure wound therapy, electric pump, each)) received in January 2016 were medically necessary for treatment of the member's condition.

The MAXIMUS physician consultant indicated that the member's open wound was treated with medically necessary negative pressure wound vacuum. This treatment continued through April 2016. The Health Plan denied coverage for some of the dressing sets that the member received in January 2016 on the basis that plan language only covers 15 units per month for such care. The physician consultant indicated that the attending physician provided documentation of the medical necessity for use of more than 15 units per month of dressing sets in this member's care.

Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that the additional medical supplies . . . received in January 2016 were medically necessary for treatment of the member's 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 IRO's 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 analysis is based on extensive experience, expertise, and professional judgment. In addition, the IRO's recommendation is not contrary to any provision of the Petitioner's coverage. MCL 550.1911(15). The Director, discerning no reason why the IRO recommendation should be rejected in this case, adopts the IRO analysis and finds that the denied wound care medical supplies the Petitioner received in January 2016, were medically necessary to treat her condition and therefore are a covered benefit under the terms of the certificate.

V. ORDER

The Director reverses BCBSM's April 18, 2016, final adverse determination.

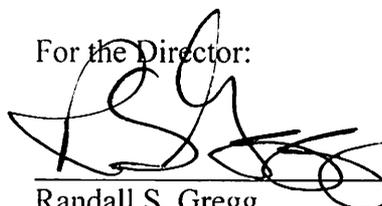
BCBSM shall immediately, MCL 550.1911(17), cover the denied wound care medical supplies provided to the Petitioner on January 4 and January 20, 2016. Further, BCBSM shall, within seven days of providing coverage, furnish the Director with proof it has implemented this Order

To enforce this Order, the Petitioner may report any complaint regarding its 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. 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 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