

**STATE OF MICHIGAN**  
**DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES**  
**Before the Director of Insurance and Financial Services**

**In the matter of:**

██████████  
**Petitioner**

**v**

**HealthPlus of Michigan, Inc.**  
**Respondent**

**File No. 147943-001**

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**Issued and entered**  
**this 18<sup>th</sup> day of June 2015**  
**by Randall S. Gregg**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On May 19, 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 as a dependent through HealthPlus of Michigan, Inc. (HealthPlus), a health maintenance organization. The benefits are defined in the HealthPlus *Individual Signature HMO Individual Subscriber Contract* and related rider.

The Director notified HealthPlus of the external review request and asked for the information it used to make its adverse determination. HealthPlus furnished its response on May 19, 2015. After a preliminary review of the material received, the Director accepted the request on May 26, 2015.

To address the medical issue in this case, the Director assigned it to an independent medical review organization which provided its analysis and recommendation on June 9, 2015.

**II. FACTUAL BACKGROUND**

The Petitioner has type 1 diabetes. His doctor recommended that he monitor his blood sugar levels eight to twelve times a day and prescribed test strips and lancets sufficient to perform the tests. A request for coverage for these supplies was submitted to HealthPlus by J&B Medical Supply. HealthPlus authorized coverage for only a portion of the requested supplies.

The Petitioner appealed HealthPlus's decision through its internal grievance process. At the conclusion of that process, HealthPlus issued a final adverse determination dated May 11, 2015, affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did HealthPlus correctly deny coverage for a portion of the blood sugar testing supplies requested by the Petitioner?

### IV. ANALYSIS

#### HealthPlus's Argument

In its final determination, HealthPlus wrote:

Your case has been reviewed by a [HealthPlus] Medical Director, a D.O. board certified in Family Practice. He has determined to uphold the denial.

His decision is based on the enclosed Medicare National Durable Medical Equipment Regional Carrier (DMERC) Guidelines....

This denial is further supported by your enclosed Subscriber Contract; section **Durable Medical Equipment**, which states

*(Covered services) when ordered and/or authorized in advance by the Member's Primary Care Physician, a Specialist Physician to whom the Member is Appropriately Referred, and/or HPM.*

Documentation submitted by [REDACTED], which included medical records, indicated that you electively test 8-10 times per day in an effort to avoid episodes of hypoglycemia and/or hyperglycemia, however medical documentation did not indicate that this frequency was medically necessary. The documentation you submitted with your grievance was duplicate to medical records originally provided. Since no additional information was submitted for review the denial was upheld as over quantity of services are not medically necessary.

#### Petitioner's Argument

In an April 27, 2015 letter submitted with his external review request, the Petitioner wrote:

As a type 1 diabetic for 33 years, I have been meticulous with controlling my sugars and this has allowed me to avoid severe hypoglycemic and hyperglycemic episodes as well as diabetic complications such as retinopathy, neuropathy,

nephropathy, etc. I have been able to achieve this control by using an insulin pump and checking my blood sugars often.

I joined HealthPlus 1/1/2014 and expected to be able to continue my careful monitoring of my sugars. However, I was soon informed that HealthPlus does not cover more than six test strips per day. I am accustomed to checking my sugars 8-10 times daily. This does not even include the glucometer manufacturer's recommendation to do control tests regularly as well, which further depletes my supply.

In addition, I was even more frustrated when HealthPlus representatives told me that I was not insulin dependent (despite copies of my endocrinologist's office notes, evidence of me filling prescriptions for insulin, and using an insulin pump and ordering supplies for it) and used this as the reason to deny my additional test strips. Making matter worse, at one point HealthPlus told me that my insulin pump should check my blood sugars, another gross misunderstanding which shows a lack of education in your diabetes department.

As a member, I again ask you to approve additional test strips as per my endocrinologist's orders....

In a progress noted dated March 4, 2015, Petitioner's physician directed that he monitor his blood sugar level eight to twelve times a day.

#### Director's Review

To determine if the prescribed quantity of testing supplies is medically necessary the Director assigned this case to an independent review organization (IRO) 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 certified by the American Board of Internal Medicine with a subspecialty in endocrinology, diabetes and metabolism. The reviewer is an instructor at a university medical school and is published in peer-reviewed medical literature. The IRO reviewer's report included the following analysis and recommendation:

The enrollee does meet Medicare's National Durable Equipment Regional Carrier (DMERC) Guidelines for additional diabetic supplies and the additional diabetic supplies are medically necessary for the treatment of the enrollee's condition.

\* \* \*

The Medicare guidelines say that three checks a day are covered for insulin use; in order for higher quantities to be provided, we must see the office note documenting severity of symptoms and review of beneficiary log, and information about medication dosage adjustment. The physician's progress notes dated, March 4, 2015 by [REDACTED] indicate the enrollee has had type 1 diabetes

since the age of seven. He is on insulin pump therapy, is knowledgeable and able to manipulate his pump. He does have hypoglycemic reactions which are significant about once a month and has hypoglycemic unawareness. Frequent blood glucose level testing throughout the day is completed in order to avoid hypoglycemia and hyperglycemia and continued glucose monitoring 8-12 times daily was recommended. Multiple logs from multiple machines were reviewed. The enrollee is adjusting his food intake and insulin bolus amounts to the blood glucose level. The medical reason given in the note is that the enrollee has hypoglycemia unawareness and this frequency of checking his blood sugar levels helps him avoid severe lows. Hence, the criteria are met.

In an enrollee with hypoglycemic unawareness, multiple checks per day (eight to twelve is not unusual) and/or continuous glucose monitoring is now standard of care. This helps avoid low blood glucose levels and sometimes can help restore hypoglycemic awareness.

Patients can avoid low blood glucose levels by monitoring more often and perhaps raising their blood glucose goals. The National Diabetes Information Clearinghouse (NDIC) noted that hypoglycemia unawareness develops when frequent episodes of hypoglycemia lead to changes in how the body reacts to low blood glucose levels. People with hypoglycemia unawareness may need to check their blood glucose level more often so they know when hypoglycemia is about to occur.

In conclusion, the enrollee needs to check blood glucose levels often to help avoid hypoglycemic unawareness and severe chemical reactions. This is standard of care in an enrollee like this with severe hypoglycemic unawareness and long duration of type 1 diabetes mellitus. Therefore the additional diabetic supplies are medically necessary for treatment of the enrollee's condition.

It is the recommendation of this reviewer that the denial of coverage issued by HealthPlus of Michigan, Inc. for additional diabetic supplies be overturned.

[References omitted.]

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 analysis is based on extensive experience, expertise, and professional judgment. The Director can discern no reason why the IRO's recommendation should be rejected in the present case. In addition, the IRO recommendation is not contrary to any provision of the Petitioner's certificate of coverage. See MCL 550.1911(15).

The Director finds that the requested diabetic testing supplies are medically necessary to treat the Petitioner's condition and are therefore covered benefits.

**V. ORDER**

The Director reverses HealthPlus's May 11, 2015, final adverse determination. HealthPlus shall immediately provide coverage for the requested diabetes testing supplies and 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 Sections, at this toll free telephone 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:



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Randall S. Gregg  
Special Deputy Director