PART C – Decision under Appeal

The decision under appeal is the reconsideration decision of the Ministry of Social Development and Social Innovation (the ministry) dated 05 April 2017 that denied the appellant's request for funding of a 2-month trial rental of a continuous positive airway pressure (CPAP) device and associated accessories and supplies. The ministry determined that the request met the requirements set out in sections 3.9(2)(a) and (b) of Schedule C of the Employment and Assistance for Persons with Disabilities Regulation, as the item had been prescribed by a medical practitioner and that a respiratory therapist had performed an assessment that confirmed the medical need for the item. However, the ministry found that the request did not meet the requirement set out in section 3(1)(b)(i) of Schedule C, that the family unit receive the pre-authorization of the minister for the item requested. The ministry also held that the request does not meet the provision set out in section 3.9(2)(c) of Schedule C that the minister is satisfied that the item is medically essential for the treatment of moderate to severe sleep apnea.

PART D – Relevant Legislation

Employment and Assistance for Persons with Disabilities Regulation (EAPWDR), Schedule C, sections 3 and 3.9.

PART E – Summary of Facts

The information before the ministry at reconsideration is summarized below:

1. The appellant is a recipient of disability assistance.

2. A medical Equipment Request and Justification dated 29 November 2016, completed by a registered respiratory therapist (RRT). The appellant's medical condition is described as: "Mild obstructive sleep apnea, severe while in REM sleep, as diagnosed by PSG [polysomnography]". The recommended equipment is a CPAP with humidifier, mask and modem for monitoring. Attached to the Request are:
   - A quote dated 29 November 2016 for a 2-month rental of CPAP unit with mask in the amount of $725.00.

   - A PSG Report of a sleep study conducted on 21 June 2016, signed by a neurologist. The neurologist's impression is: "The findings are consistent with an overall mild obstructive sleep apnea. However, it has worsened to become severe in degree during REM sleep. There is also frequent arousal suggested of maintenance insomnia." His recommendation is: "Treatment for insomnia is recommended and if patient continues to have significant non-refreshing sleep especially with frequent nocturnal awakening, then treatment for sleep apnea should also be considered."

     In the reconsideration decision, the ministry noted the following PSG results:
     Oxygen saturation: mean SpO_2% - 94
     Index: Apnea & Hypopnea – 7.3
     REM index – 31.6
     NREM index – Apnea & Hypopnea – 4.4.

   - A fax dated 31 October 2016 from the RRT to the appellant's physician, describing a recent visit by the appellant to the RRT's office, where she set up a CPAP machine and tried out a few masks to see how they worked and felt. The RRT stated that the staff at her residence had suggested that a titration study on a CPAP in the appellant's own room might be better tolerated. The RRT would also contact the neurologist to see if he would recommend a titration study at the sleep clinic or if a home titration would be adequate. The RRT attached a pre-populated template for the physician's convenience.

   - A pre-populated prescription note dated 31 October 2016, signed by a locum on behalf of the appellant's physician, for CPAP therapy for treatment of obstructive sleep apnea, with CPAP pressure range/settings 5-15cmH_2O and indicating that all CPAP and bi-level therapy requires humidification, mask interface and is required indefinitely.

   - The fax cover sheet from the RRT for the above documents, dated 29 November 2016 headed "Dear Adjudicator" states:
     This client does not meet the above listed screening criteria, however, a respiratory therapist or medical practitioner has clearly outlined the medical necessity for CPAP therapy in writing and attached the document to this request (i.e. abnormal SpO_2, co-morbid health conditions, cardiac reports, diagnostic reports etc.)

3. On 24 January, 2017, the ministry sent a letter to the appellant advising her that the request for funding the 2 month CPAP rental was denied.

4. Coincidentally, on 24 January 2017 the following documents from the RRT were received by the ministry:
    - A quote dated 24 January 2017 for a purchase of a CPAP machine, humidifier and filters, in the amount of $1936.00.

    - The results of the sleep study conducted by the RRT on 26 December 2016. This study was conducted while the appellant was on CPAP. The desaturation event index with events greater than 10 seconds per sampled hour is 2.7.

    - A compliance report indicating usage by the appellant of CPAP between 18 November 2016 and 23 January 2017.

5. Letter from the appellant's physician dated 05 March 2017. The physician writes:

    "… I gather she was denied because you were informed that [the appellant] has Mild Sleep Apnea. I am not sure where this information/designation "Mild" came from.

    The appellant has significant daytime sleepiness with Epworth score of 10-15/24. I have enclosed the reports from [a respirologist] and [the neurologist] and in all of the reports they say she has moderate sleep disordered breathing and the neurologist's comments on a very high Apnea - hypopnea index.

    She has trialed on CPAP and it has made a significant change to her functioning. The staff at her supportive home has noted a significant improvement in her mood and social well being since starting the CPAP. I think it would be a significant disservice to patient to be denied this benefit."

Attached to this letter are the following documents:

- Laboratory Investigation Results, with a collection date of 15 Mar 2016, as reported by a respirologist. Interpretation: "Given the slightly elevated desaturation event index in the presence of saw-tooth deviations on the oxygen saturation wave form, these findings are consistent with a diagnosis of obstructive sleep apnea." The respirologist suggests that she may benefit from a trial of nocturnal positive pressure ventilation. Follow-up testing on CPAP would be appropriate to confirm that the desaturation event index improves and the saw-tooth deviations resolve.

- Letter dated 07 May 2016 from the neurologist, the appellant having been referred to him because she complained of being a light sleeper. The appellant would wake up a couple of times at night and take 10 to 15 minutes to fall back to sleep. When she wakes up in the morning she feels unrested, averaging eight hours of sleep. She scored 10/24 on the Epworth sleepiness scale. She reports to having loud snoring, snorting, gasping, choking and twitching reported by family members. She has been observed to have some pause in breathing. She is not aware of waking self with snoring, snorting, gasping and choking. The neurologist states that the appellant is suspected to have sleep disorder breathing based on the history provided. She would benefit from an overnight PSG. She also seems to have sleep onset insomnia as well, therefore, initiation of [antidepressant medication] will also be considered for her if she needs to be on CPAP so that she can adapt to CPAP better.

- Letter dated 10 August 2016 from the neurologist, who writes:

    "This is a [woman in her mid 30's] who had fairly fragmented sleep as well as frequent nocturnal awakening and undergone sleep study. Unfortunately, the study reveals

fairly poor sleep efficiency of only about 40%. During the study, she did have some sleep events but they are more so during REM sleep. However, because she only spent little time in REM sleep, AHI is actually quite high which can be falsely elevated."

6. The appellant's Request for Reconsideration dated 22 March 2016. Attached were most of the documents summarized above.

Notice of Appeal

The appellant's Notice of Appeal is dated 18 April 2017. Under Reasons, the appellant's advocate writes, "This young developmentally delayed female is benefitting greatly from the use of the CPAP. Due to her disabilities an accurate observation was not conducted. Her results were based on very minimal observation."

The hearing

At the hearing, the appellant explained that for the sleep study at the sleep clinic she did not feel comfortable and did not actually sleep much. Her advocate stressed that the results of the sleep study had likely been affected because the appellant was by herself at the sleep clinic and felt anxious during the testing. The advocate stated that she was in the process of arranging for one of the appellant's specialists to conduct a second test in the appellant's own room at her residence in order to obtain a more accurate result. The advocate stated since the equipment has been installed in her home, the appellant "feels wonderful" and the "benefits have been amazing." The advocate volunteered that there was not enough evidence of the apnea being moderate or severe based on the initial testing.

The ministry stood by its position at reconsideration. The ministry representative outlined the standard procedure for pre-approval of medical equipment, but stated that it is not uncommon for a supplier to loan a CPAP machine for two months, taking "a calculated risk" of not being reimbursed by the ministry for rental if the ministry is not convinced the CPAP legislative requirements have been met.

Admissibility of new additional information

The panel accepts the information provided in the Notice of Appeal and in the statements by the appellant and her advocate at the hearing as explanation for arranging a new sleep study if this appeal is not successful.

PART F – Reasons for Panel Decision

The issue in this appeal is whether the ministry was reasonable in denying the appellant's request for funding of a 2-month trial rental of a CPAP device and associated accessories and supplies. More specifically, the issue is whether the following ministry determinations were reasonably supported by the evidence or were a reasonable application of the legislation in the circumstances of the appellant:

- The request did not meet the requirement set out in section 3(1)(b)(i) of Schedule C of the EAPWDR that the family unit receive the pre-authorization of the minister for the item requested.
- The request does not meet the requirement set out in section 3.9(2)(c) of Schedule C that the minister is satisfied that the item is medically essential for the treatment of moderate to severe sleep apnea.

The relevant legislation is from the EAPWDR, Schedule C:

Medical equipment and devices

3 (1) Subject to subsections (2) to (5) of this section, the medical equipment and devices described in sections 3.1 to 3.12 of this Schedule are the health supplements that may be provided by the minister if

(a) the supplements are provided to a family unit that is eligible under section 62 *[general health supplements]* of this regulation, and

(b) all of the following requirements are met:

(i) the family unit has received the pre-authorization of the minister for the medical equipment or device requested;

(ii) there are no resources available to the family unit to pay the cost of or obtain the medical equipment or device;

(iii) the medical equipment or device is the least expensive appropriate medical equipment or device.

(2.1) For medical equipment or devices referred to in section 3.9 (1) (b) to (g), in addition to the requirements in that section and subsection (1) of this section, the family unit must provide to the minister one or both of the following, as requested by the minister:

(a) a prescription of a medical practitioner or nurse practitioner for the medical equipment or device;

(b) an assessment by a respiratory therapist, occupational therapist or physical therapist confirming the medical need for the medical equipment or device.

Medical equipment and devices — breathing devices

3.9 (1) Subject to subsection (4) of this section, the following items are health supplements for the purposes of section 3 of this Schedule:

(a) if all of the requirements set out in subsection (2) of this section are met,

(i) a positive airway pressure device,

(ii) an accessory that is required to operate a positive airway pressure device, or

(iii) a supply that is required to operate a positive airway pressure device;

(b) if the minister is satisfied that the item is medically essential to monitor breathing,

(i) an apnea monitor,

(ii) an accessory that is required to operate an apnea monitor, or

(iii) a supply that is required to operate an apnea monitor;

(f) if the minister is satisfied that the item is medically essential to moisturize air in order to

allow a tracheostomy patient to breathe,

(i) a medical humidifier,

(ii) an accessory that is required to operate a medical humidifier, or

(iii) a supply that is required to operate a medical humidifier;

(2) The following are the requirements in relation to an item referred to in subsection (1) (a) of this section:

(a) the item is prescribed by a medical practitioner or nurse practitioner;

(b) a respiratory therapist has performed an assessment that confirms the medical need for the item;

(c) the minister is satisfied that the item is medically essential for the treatment of moderate to severe sleep apnea.

(4) A ventilator is not a health supplement for the purposes of section 3 of this Schedule.

Analysis

Degree of sleep apnea

Under section 3.9(2)(c) of Schedule C of the EAPWDR, the minister must be satisfied that a CPAP device is medically essential for the treatment of moderate to severe sleep apnea. As the legislation does not define "moderate to severe sleep apnea," the panel considers it reasonable that the ministry would look to a generally accepted diagnostic approach based on measurable test results to determine whether the requestor met this requirement. Attached to the reconsideration decision is an the appendix providing a page from the BC Ministry of Health WebLink describing sleep apnea and the diagnosis of its degree:

> Sleep apnea occurs when you regularly stop breathing for 10 seconds or longer during sleep. It can be mild, moderate, or severe, based on the number of times an hour that you stop breathing (apnea) or that airflow to your lungs is reduced (hypopnea). This is called the apnea-hypopnea index (AHI).
> • **Mild apnea.** Mild apnea is defined as 5 to 14 episodes of apnea or reduced airflow to the lungs every hour…
> • **Moderate apnea.** Moderate apnea is defined as 15 to 29 episodes of apnea or reduced airflow to the lungs every hour…
> • **Severe apnea.** Severe apnea is defined as 30 or more episodes of apnea or reduced airflow to the lungs every hour…
> Sleep apnea may be classified differently in children, because they are still developing and they normally breathe at a faster rate than adults do.

In the reconsideration decision, the ministry stated that these AHI ranges are consistent with the current consensus of the American Academy of Sleep Medicine. The ministry also noted that in addition to the AHI, other factors used in diagnosing and assessing sleep apnea include the respiratory disturbance Index, daytime sleepiness, as well as strong indicators for the presence of sleep apnea (i.e. BMI, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or stroke). The ministry noted that assessment of these factors are summarized in the sleep study report. The panel notes that while many of these factors were listed in that report, none of the appellant's medical practitioners has provided an analysis or opinion that the cumulative impact of any of these factors would serve to change the diagnosis from mild to moderate or severe sleep apnea.

In the reconsideration decision, the ministry reviewed in detail the materials submitted on the appellant's behalf by her medical practitioners and the RRT. In doing so, the ministry quoted the original decision and provided commentary as to whether any of the documents submitted after the original decision supported a finding of moderate to severe sleep apnea.

The ministry stood by the original decision made on 24 January 2017, which noted that the assessment performed by the neurologist on 21 June 2016 (the sleep study or PSG report) shows the appellant's AHI at 7.3. This is consistent with mild obstructive sleep apnea (OSA), not the moderate to severe sleep apnea required under section 3.9(2)(c) of Schedule C of the EAPWDR. The original decision also notes that the appellant's average oxygen saturation during the PSG was 94%; this does not support the presence of a significant sleep disturbance. For these reasons the ministry denied the appellant's request for a CPAP trial.

The ministry also referred to the sleep study conducted by the respirologist on 15 March 2016, which indicated a DEI ([oxygen] desaturation event index) of 9.8 – a result that according to the ministry is also within the mild range for sleep apnea.

Referring again to the sleep study report, the ministry noted the sleep clinic neurologist had confirmed that the appellant has mild sleep apnea, and had recommended treatment for insomnia, and only recommended treatment for apnea if symptoms of non-refreshing sleep and frequent nocturnal awakening continued. The ministry also noted that the appellant's physician suggests in her letter on 05 March 2017 that both the respirologist and the sleep clinic neurologist report that the appellant has moderate sleep disordered breathing. Considering that the legislation refers specifically to he degree of sleep apnea and not to “sleep disordered breathing,” the panel considers reasonable the ministry finding that this reference does not contain an explicit statement from either medical practitioner that the appellant has moderate to severe sleep apnea.

As noted in Part E above, at the hearing the appellant's advocate did not dispute the ministry's findings based on the test information provided. Her concern is that the ministry’s findings were based on the PSG on 21 June 2016 at the neurologist’s sleep clinic, where the appellant did not actually sleep very much and had very little REM sleep. She is in the process of arranging for a PSG to be conducted in the appellant's own room at her residence, where she will be more comfortable in familiar surroundings. She expects that the new PSG will show that the appellant has moderate to severe sleep apnea.

On the basis of the above analysis, the panel finds that the ministry was reasonable in relying on the PSG-reported AHI as an indicator of degree of sleep apnea. Given that an AHI of 7.3 is in the mild range and that the sleep clinic neurologist accordingly had assessed the appellant's sleep apnea as mild, the panel therefore finds that the ministry reasonably determined that there is not enough evidence to demonstrate that a CPAP trial with mask is medically essential for the treatment of moderate to severe sleep apnea

Ministry pre-authorization

In reviewing the materials received by the ministry after the original decision, the ministry noted the compliance report indicating CPAP usage between 18 November 2016 and 23 January 2017. The ministry noted that it did not approve a two-month trial of CPAP machine. The ministry went on to state that it appeared that the CPAP provider went ahead with a two-month trial anyway. This started 11 days before the application for the two-month trial was submitted to the ministry. Finding that the appellant's desaturation Index improved with the use of a CPAP machine does not obviate the fact that her request for the two-month trial was denied by the ministry based on the results from the sleep clinic neurologist who confirmed that the appellant had mild sleep apnea, recommended treatment for insomnia, and only recommended treatment for apnea if symptoms of non-refreshing sleep and frequent nocturnal awakening continued after treatment. The panel notes that there is no information provided by any of her medical practitioners that she has been treated for insomnia.

The ministry found that, under the circumstances, the appellant's request for funding for a 2-month rental of the CPAP machine does not meet the requirement set out in the EAPWDR, Schedule C, section 3(1)(b)(i), that the family unit has received the preauthorization of the minister for the medical equipment or devices requested.

The ministry states that there is an exception in policy that allows the ministry to accept payment responsibility for medical equipment purchased without prior approval in cases of a life-threatening emergency. However, information is not submitted to establish that a life-threatening emergency existed.

The panel is of the view that the ministry cannot develop policy that is inconsistent with or otherwise contradicts the requirements set out the Act or Regulation. The EAPWDR in this case does not contemplate discretion with respect to pre-authorization. Accordingly, the panel will limit its discussion to the legislative requirements.

The legislation clearly stipulates that for any medical equipment or device listed in sections 3.1 to 3.12 of Schedule C of the EAPWDR, including a positive airway pressure device set out in section 3.9, the pre-authorization of the minister is required. The panel therefore finds that the ministry was reasonable in determining that, as the appellant's request for funding for a 2-month CPAP trial with mask was denied on 24 January 2017, she did not receive the pre-authorization from the ministry before commencing the trial and therefore she failed to meet this legislative requirement for funding the 2-month trial.

Conclusion

Based on the foregoing analysis, the panel finds that the ministry's decision to deny the appellant's request for a 2-month trial of the CPAP device and associated accessories and supplies is reasonably supported by the evidence. The panel therefore confirms the ministry's decision. The appellant's appeal is thus not successful.