STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-29626 QHP

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented himself at hearing. [redacted] represented the Medicaid Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for binaural hearing aids?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary enrolled in [redacted], a Michigan Medicaid health plan.

2. The Appellant suffers hearing loss in each ear.

3. The Appellant's audiologist requested prior authorization on his behalf for binaural hearing aids on [redacted].

4. [redacted] (CMC) denied the request for binaural hearing aids, citing lack of clinical information to support the request and discontinuation of coverage for hearing aids effective [redacted].

5. The MHP cited the service date of after [redacted], as a reason for denial at hearing.

6. The Appellant's hearing aid supplier made the request for hearing aids via telephone.

7. The Appellant was notified of the denial on [redacted].

8. The Appellant requested a formal, administrative hearing on [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

Fee-for-service Medicaid beneficiaries are subject to the prior approval process found in the Medicaid Provider Manual. MHP beneficiaries are entitled to the same benefits as fee-for-service Medicaid beneficiaries. Thus, MHP beneficiaries may not be denied a service that would otherwise be provided a fee-for-service beneficiary, assuming Medicaid Provider Manual criterion has been satisfied.

Standards of coverage for binaural hearings aids are specifically addressed in the Medicaid Provider Manual. Prior authorization for coverage is not even needed if standards of coverage guidelines are met. If standards of coverage are met, presumably, it is a medically necessary covered service.

The Medicaid Provider Manual set forth the coverage guidelines for hearing aids that were effective prior to the July 1, 2009, change in coverage. Pertinent sections follow:

1.3 COVERED SERVICES

Medicaid covers the following services when provided by a licensed hearing aid dealer or licensed audiologist:

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Alternative listening devices for beneficiaries over age 21

1.4 NONCOVERED ITEMS

Noncovered items include, but are not limited to, the following:

- Hearing aids that do not meet U.S. Food and Drug Administration (FDA) and Federal Trade Commission requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics
- Hearing aids delivered more than 30 days after a beneficiary becomes ineligible for Medicaid

* * *

1.12 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain services before the services are rendered. To determine which services require PA, refer to the Standards of Coverage, Limitations and Payment Rules Section of this Chapter or the Hearing Aid Dealers Database on the MDCH website.

PA is required for the following situations:

- All hearing aids, except conventional analog hearing aids meeting the bilateral standards of coverage.
- Alternative Listening Devices.
- Services and items that exceed quantity limits, frequency limits, or established fee screen.
- For a NOC code.

* * *

2.2 CONVENTIONAL ANALOG HEARING AIDS

2.2.A. STANDARDS OF COVERAGE - BILATERAL HEARING LOSS

Age Under 21 Years	Conventional analog monaural or binaural hearing aid: • Bilateral hearing loss documented by an audiogram showing hearing loss of 25dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz; or • Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	Conventional analog monaural hearing aid: • Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz; and • A speech recognition score of at least 20 percent in the ear to be aided.
	Conventional analog binaural hearing aid: • **Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz.** • **A speech recognition score must be grater than 20 percent in both ears;** • **The four frequency average between ears must not exceed 20 dB HL; and** • **The speech recognition scores must not differ between ears by more than 30 percent.**

*** * ***

2.2.D. PRIOR AUTHORIZATION REQUIREMENTS

PA is not required for either monaural or binaural conventional analog hearing aids if the bilateral standards of coverage are met.

PA is required for the following:

- Replacement aids within three years.

- Conventional analog hearing aids when the bilateral standards of coverage are not met.
- Conventional analog hearing aids for unilateral hearing loss.

Medicaid Provider Manual
Hearing Aid Dealers, Version Date 4-1-08.

Here, the MHP has presented uncontested evidence that the supplier did not provide any clinical information when the request for the hearing aids was made. It cannot be determined if the standards of coverage were met or not without evidence of the clinical information supporting the request. The Appellant did not present any clinical information to support the request, nor evidence to contradict the claim of the MHP that insufficient information was supplied before the change in coverage became effective July 1, 2009.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the request for hearing aids because there was no clinical information supplied to support a coverage determination.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/2/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.