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. 2009-35464 QHP
Case No. [redacted]

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 on [redacted]. The Appellant appeared without representation. Her witness was her spouse, [redacted]. [redacted] represented [redacted]). His witness was [redacted], medical director.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for a king size Flex-a-Bed?

FINDINGS OF FACT

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

1. At the time of hearing the Appellant is a disabled [redacted] Medicaid and social security beneficiary. (Appellant's Exhibit #1 and #2)

2. The Appellant has been enrolled with [redacted] since [redacted]. (Appellant's Exhibit #1)

3. On [redacted], the MHP received a request from the DME supplier, [redacted]., for a king size Flex-A-Bed. (Respondent Exhibit A, p. 2)

4. The request was reviewed and denied as a non-covered item under [redacted] of Coverage Guidelines and incorrect billing code. (Respondent's Exhibit A, pp. 1, 2)

5. The Appellant, her physican and the supplier were notified of the denial on [redacted]. (Respondent Exhibit A, p. 2)

6. The instant request for hearing was received on [redacted]. (Appellant's Exhibit #1)

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 I-Z.
>
> Article II-G, Scope of Comprehensive Benefit Package, Contract, 2008, p. 32.
>
> 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 utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.

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.

Supra, Contract, §II-P p. 66, [*See also* Medicaid Provider Manual, Medical Supplier, §1.2, October 1, 2009, at page 2]

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The MHP witness testified that there was inadequate information provided as well as an inaccurate Medicaid billing code to determine DME coverage under Medicaid guidelines and the MHP contract with the state. *See* Respondent's Exhibit A, p. 5. The Appellant was advised of this lack of information at hearing, but stated her desire to pursue this appeal.

The Appellant testified that she and her spouse need the Flex-A-Bed owing to their mutual disabilities. Her spouse confirmed that testimony.

At hearing arrangements were made on the MHP's motion to assist the Appellant in securing necessary documentation from her physican to enable the MHP to adequately

review the request. The MHP witness credibly testified that there was inadequate information presented for an appropriate review.

Although the Appellant produced ample evidence regarding need - there was no dispute about disability.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Respondent's denial of the Appellant's request for a king sized Flex-A-Bed [code E1399] was properly denied as a non-covered item under the MPM and the MHP coverage criteria.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/6/2009

***** 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.