

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant

_____ /

Docket No. 2009-24129 QHP

Case No. ██████████

Load No. ██████████

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 ██████████. The Appellant appeared without representation. She had no witnesses. ██████████, represented the Medicaid Health Plan (MHP). His witness was ██████████.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for an ultrasonic osteogenesis stimulator?

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 ██████████ Medicaid beneficiary. Appellant's Exhibit #1.
2. The Appellant has been enrolled with ██████████ since ██████████.
3. On or about ██████████, the MHP received a request from the DME supplier, ██████████ for an Exogen bone healing system. Respondent Exhibit A, p. 2.
4. The request was reviewed and denied as a non-covered item under ██████████ coverage guidelines. Respondent's Exhibit A, pp. 1, 2.

5. The Appellant, her physician and the supplier were notified of the denial on ██████████. Respondent Exhibit A, p. 2.
6. The instant request for hearing was received on ██████████. 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.

2.29 OSTEOGENESIS STIMULATORS

Definition An Osteogenesis Stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.....

The stimulator includes, but is not limited to, the osteogenesis stimulator, electrical, noninvasive, other than spinal applications and osteogenesis stimulator, electrical, noninvasive, spinal applications.

Medicaid Provider Manual; Medical Supplier
Version Date: July 1, 2009;
Page 54¹

¹ This edition of the MPM at§2.29 [medical supplier] is identical to the version in place at the time of the Appellant's appeal.

Docket No. 2009-24129 QHP
Decision and Order

The MHP witness testified that an ultrasonic osteogenesis bone growth stimulator was not a covered benefit under either the MHP coverage guidelines or the Medicaid Provider Manual. The MHP medical director, [REDACTED], advised that other products were coded for approval at code numbers E0747 and E0748. The Appellant was advised of these alternative available services at hearing, but stated her desire to pursue this appeal.

The Appellant testified that she needs the bone growth stimulator device to stimulate bone growth in her left hand following the residuals of a serious automobile accident and surgery to her left hand. She stated at hearing that she intended to take the existing coverage letter to her physician for review after [REDACTED] advised her that approval would be contingent on stimulator use approximately (9) nine months post fracture or surgery. The Appellant acknowledged several surgeries beginning in [REDACTED].

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 an ultrasonic osteogenesis stimulator [code E0760] 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: 7/29/2009

***** 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.