STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-16793 QHP
[redacted]

DECISION AND ORDER

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

After due notice, a hearing was held [redacted] appeared on her own behalf [redacted], Grievance Coordinator, represented [redacted], the Medicaid Health Plan (hereinafter MHP). [redacted], Customer Service Director and Grievance Office, and [redacted], Medical Director, appeared as witnesses for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for an automatic blood pressure machine?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted] female Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a request for an automatic blood pressure machine from [redacted] (Exhibit 1, page 4)

3. On [redacted], the MHP sent the Appellant's physician requests for additional information. The Appellant's physician did submit a prescription and answer the questions from the MHP. (Exhibit 1, pages 5-6)

4. On [redacted] the MHP sent the Appellant a denial notice stating that the criteria for coverage of an automatic blood pressure monitor machine were not met. (Exhibit 1, pages 7-10)

5. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, page 11)

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 [redacted], 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 coverage(s) and limitations. (Emphasis added by ALJ)* 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 coverage(s) 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.

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

2.4 BLOOD PRESSURE MONITORING

Definition
Blood pressure monitoring includes manual and automatic blood pressure units.

Standards of Coverage
A manual blood pressure unit may be covered for a beneficiary under the age of 21 when:

- Daily titration of medications is required for renal disease.
- A cardiovascular condition is present that affects blood pressure (e.g., congenital heart disease).
- A brain lesion or cancer tumor is present that affects blood pressure.
- A medication regimen is present that affects blood pressure.

Coverage for beneficiaries age 21 and over with uncontrolled blood pressures when one of the following is present:

- Fluctuation in blood pressure as a result of renal disease.
- Medications are titrated based on daily blood pressure readings.

An automatic blood pressure monitor is covered when:

- Standards of coverage for a manual unit have been met.
- Beneficiary is age 11 or over.
- Economic alternatives (such as a manual blood pressure unit) have either been tried or ruled out prior to requesting authorization of an automatic blood pressure monitor.

Documentation
The documentation must be less than 30 days old and include:

- Diagnosis/medical condition pertaining to the need for the blood pressure monitor.
- Complete physician's treatment plan, including current blood pressure medications, frequency of checks, and specific patient protocol in case of an abnormal reading.
- The medical reason a manual blood pressure unit cannot be used (for beneficiaries over the age of ten years).
- Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (**required for coverage under CSHCS**).

PA Requirements
PA is required for all blood pressure units.

Payment Rules
A blood pressure monitor is considered a **purchase only** item.

Department of Community Health,
Medicaid Provider Manual, Medical Supplier Section
Version Date: October 1, 2009, Pages 21-22

The MHP testified that the information submitted with the request did not show that the Appellant met the Standards of Coverage for an automatic blood pressure monitor. This ALJ has reviewed the submitted information and agrees that the information provided did not document that economic alternatives, such as a manual blood pressure unit, have either been tried or ruled out. The Appellant's doctor reported that there was no medical reason a manual blood pressure unit could not be used. (Exhibit 1, page 6) While this ALJ's photocopy of the prescription written by the Appellant's doctor is not very clear, the MHP testified that it was for a blood pressure cuff, but not specifically an automatic cuff.

The Appellant testified that she has a manual blood pressure cuff but it is difficult to use due to rheumatoid arthritis in her right hand. Therefore, the Appellant explained, it takes two people to use the manual cuff. The Appellant expressed how important it is to have correct readings to provide to her doctor and stated that she can get a wrong reading from the manual unit.

The testimony indicated that the Appellant was going to get another letter from her doctor to support that an automatic blood pressure unit was necessary. However, the Appellant acknowledged that she does not have the letter yet because the resident has to have everything go through the primary doctor and needed more time.

The MHP demonstrated that based on the submitted information, the Appellant did not meet criteria for approval of an automatic blood pressure monitoring unit. As such, the MHP properly denied coverage.

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 Appellant's request for an automatic blood pressure monitor based on the available information.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/19/2010

***** 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.