STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-20788 QHP
[redacted] 14129790

[redacted],

Appellant
_____/

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]. [redacted], attorney, represented the Appellant. [redacted] appeared and testified.

[redacted] Health Plan was represented by [redacted], Customer Services Director. [redacted], RN Director of Health Services, and [redacted], Grievance and Appeals Coordinator, appeared as a witness for [redacted] Health Plan. [redacted] Health Plan is a Department of Community Health contracted Medicaid Health Plan (hereinafter MHP).

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for a vascularized lymph node transfer?

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 who is currently enrolled in [redacted] Health Plan, a Medicaid Health Plan (MHP).

2. The Appellant underwent treatment for metastatic breast cancer in [redacted] including mastectomy, resection of lymph nodes, radiation and chemotherapy. (Appellant Testimony and Appellant's Exhibit A, Attachments 3 and 4)

3. As a result of the breast cancer treatments, the Appellant developed lymphedema of her right arm. (Appellant Testimony and Appellant's Exhibit A, Attachments 3 and 4)

4. On [redacted], the MHP denied the Appellant's request for a vascularized lymph node transfer based upon a finding that the procedure is experimental and investigational for the treatment of members with chronic obstructive lymph edema. (Petitioner's Exhibit 1, page 2)

5. On [redacted], the MHP received an appeal of the denial decision from the Appellant's family doctor's office. (Petitioner's Exhibit 1, page 6)

6. In [redacted], the MHP emailed the Michigan Department of Community Health Contract Manager, who forwarded a response from the Medical Consultant regarding the requested procedure. The Medical Consultant also determined that the proposed surgery does not conform to generally accepted standards of care and thus would be deemed investigational and not a covered Medicaid benefit. (Petitioner's Exhibit 1, age 5)

7. On [redacted], the MHP sent the Appellant's doctor's office a letter notifying her that the level 1 Appeal for was not approved after consultation with the Michigan Department of Community Health Medical Consultant. (Petitioner's Exhibit 1, pages 7-8)

8. On [redacted], the Appellant filed a request for hearing contesting the MHP denial for lymph node transplantation surgery.

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.

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. The MHP established that they contacted the Michigan Department of Community Health Contract Manager regarding the Appellant's request for the vascularized lymph node transfer. The Contract Manager forwarded an email from a Department of Community Health Medical Consultant, who determined that "this proposed surgery does not conform to generally accepted standards of care, and thus would be deemed investigational and not a Medicaid covered benefit." (Petitioner's Exhibit 1, page 5)

The Appellant's representative argued that the requested procedure is a lymph node transplantation, which should have been approved by the MHP based on Medicaid Provider Manual policy requiring MHPs to cover transplant services. Specifically, 1.1 Services Covered by Medicaid Health Plans (MHPs) of the Medicaid Health Plan portion of the Medicaid Provider Manual states "the following services must be covered by MHPs", and the following list includes "transplant services." (*Medicaid Provider Manual, Medicaid Health Plan Section, October 1, 2009 pages 1-2)*

The Appellant's representative's position that all transplant services must be covered by MHPs would ignore another relevant policy in the Medicaid Provider Manual, 1.3 Services that MHPs are Prohibited From Covering, which includes "experimental/Investigational drugs, procedures or equipment." (*Medicaid Provider Manual, Medicaid Health Plan Section, October 1, 2009 page 3)* This ALJ can not find that any and all transplant services must be covered by MHPs, regardless of whether or not they are experimental or investigational. For example, a Medicaid beneficiary requesting coverage for transplantation of a pig heart would be denied. Xenotransplantation, a transplantation of living cells, organs or tissues from one species to another, is clearly a transplant service, but would be denied not be covered as this is an experimental/investigational procedure.

The Appellant's representative next argued that the lymph node transplant surgery is not experimental. The Appellant's representative uses a definition of experimental found in the Mental Health and Substance Abuse section of the Medicaid Provider Manual:

> "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse Section, January 1, Pages 75 and 82.*
> *(Appellant's Exhibit A, Attachment 7 pages 1-2)*

However, this definition of experimental would apply to Mental Health or Substance Abuse treatment. The requested surgery is not Mental Health or Substance Abuse treatment.

The applicable policy regarding determinations that a requested procedure is experimental of investigation can be found in the State Plan under Title XIX of the Social Security Act:

> PREFACE to Attachment 3.1-A
>
> The following statement applies to all services provided, as listed on the following pages of this Attachment:
>
> > Items or services that are determined to be experimental or investigational are not covered benefits. Such determinations will be made by the Medical Services Administration, based on qualified medical advice that the items or services have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used. This advice will originate from established sources such as Medicare, National Institutes of Health, Food and Drug Administration (FDA), the AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc. The determinations are not judgments that a physicians choice is inappropriate or that a patient does not need treatment.
>
> *State Plan under Title XIX of the Social Security Act, Preface to Attachment 3.1-A, effective April 1, 1989*

In the present case, the determination that the requested surgery was experimental/investigational was in compliance with the State Plan policy. The Medical Services Administration is part of the Department of Community Health. The Department of Community Health Medical Consultant's determination was based on the generally accepted treatment protocol/standard of care, for the Appellant's condition. (Petitioner's Exhibit 1, page 5, and Petitioner's Exhibit 2, page 3, Medical Consultant's Response to the Interim Order) A single journal article is not sufficient to establish that the requested surgery has been generally accepted by the professional medical community as an effective and proven treatment. The MHP properly denied the request.

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 vascular lymph node transfer.

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: 7/22/2010

***** 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.