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

[redacted],

Appellant
_____/

Docket No. 2010-2236 QHP
[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. She had no witnesses. [redacted], grievance coordinator, represented the health plan. Her witnesses were, [redacted], utilization review manager, [redacted], clinical operations, and [redacted], medical director.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Keloid removal?

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 an [redacted], female Medicaid beneficiary. (Appellant's Ex. #1)

2. She has been covered by the MHP since [redacted]. (Respondent's Exhibit A-summary)

3. The Appellant is afflicted with history of right lobe Keloid. (Respondent's Exhibit A-summary)

4. On [redacted], the MHP [redacted] received a request for medical services from unknown physician, [redacted]., with a consultation from specialist [redacted] [Neither physican is the Appellant's primary care provider] (Respondent's Exhibit A, sub 1, 3, 4, and 5)

5. Included in the surgical request were progress notes and two (2) photographs of right Keloid scar formation on the Appellant. (Respondent's Exhibit A, sub 3, 4, and 5)

6. On [redacted] the MHP medial director denied the request for lack of referral from the Appellant's PCP, lack of medical necessity or suspicion of right lobe malignancy. Other derivative issues were detailed in the exhibit as support for the denial. (Respondent's Exhibit A, sub. 6, 7 and *See* Testimony of [redacted])

7. The Appellant was notified of the denial on [redacted]. (Respondent's Exhibit A, sub 6)

8. On [redacted], the instant request for hearing was received from the Appellant. (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 [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. 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.

Although the Contractor must provide the full range of Covered Services listed below they may choose to provide services over and above those specified.

The services provided to Enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning Services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially, pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services for individuals under age 21

- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under 21.

Article II-G. Scope of Comprehensive Benefit Package, contract, 2008, p. 32.

Furthermore, the Medicaid Provider Manual (MPM) sets forth specific service requirements for MHPs to follow:

SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services

- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21)

MPM, §1.1 (Medicaid Health Plans) January 1, 2010, pages 1 – 2[1].

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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

[1] This version of the MPM is substantially similar to the edition in place at the time of appeal.

> 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.
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> *Supra*, Contract, §II-P p. 66

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The Appellant testified that she was recently at [redacted] hospital and while confused as a patient beneficiary she said she understood that she was to have the right earlobe Keloid removed. She said she was disappointed that she had not received a decision from her physican. She said she then filed the instant appeal.

The MHP witnesses testified that Keloid removal is a covered service – however it requires supporting documentation – not provided in this instance - in addition to the lack of a referral from the Appellant's PCP.

The Respondent witnesses also verified their contractual duties (above) stating that while the Appellant is eligible for Keloid removal – more information is required from the Appellant's PCP who is shown in the records to be [redacted]. *See* Respondent's Exhibit A sub. 1.

The Appellant has the burden of proving medical necessity for right Keloid removal. She has failed to do so. The Respondent Health Plan, under these facts, appropriately denied the request for right Keloid removal.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that MHP properly denied the Appellant's request for right Keloid removal.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____

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

[redacted]
Docket No. 2010-2236
Decision & Order

cc: [redacted]

Date Mailed: 12/30/2009

***** 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.