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. 2010-3984 ABW
Case No.

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 . (Appellant) appeared and testified on her own behalf. , appeared on behalf of , a Department of Community Health medical services provider for the Adult Benefits Waiver Program.

ISSUE

Did properly deny prior authorization (coverage) for in-patient surgery?

FINDINGS OF FACT

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

1. Appellant is enrolled in the Adult Benefit Waiver (ABW) program.
2. The Appellant seeks authorization (coverage) for a planned hernia repair surgery.
3. The Appellant's doctor has indicated the surgery must be performed in-patient.

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 January 16, 2004, the federal Department of Health and Human

Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The new program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.

The Adult Benefit Waiver I (ABW I), formerly known as the State Medical Program (SMP), provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW I program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW I beneficiaries.

ABW I beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW I beneficiaries (except inpatient hospital facility services) must be provided through the health plan. CHPs administering the ABW I program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW I beneficiaries across the FFS and CHP programs…CHPs may:

- Require that services be provided through their contracted provider network, and, may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.

- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable co-payments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing

beneficiaries for the difference between the provider's charge and the CHP reimbursement.

Medicaid Provider Manual, Adult Benefits Waiver I,
Section 1, page 1, Version Date: January 1, 2006.

The Appellant is an ABW beneficiary. As such, she is entitled to only those services afforded to ABW beneficiaries. Coverage and limitations follows (entire list not included by ALJ):

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service Coverage

Ambulance Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).

Case Management Non-covered

Chiropractor Non-covered

Dental Non-covered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.

Emergency Department Covered per current Medicaid policy. For CHPs, PA may be required for non-emergency services provided in the emergency department.

Eyeglasses Non-covered

Family Planning Covered. Services may be provided through referral to local Title X designated Family Planning Program.

Hearing Aids Non-covered

Home Health Non-covered

Home Help (personal care) Non-covered

Hospice Non-covered

Inpatient Hospital *Non-covered (Emphasis supplied by ALJ)*

Lab & X-Ray Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.

Version Date: July 1, 2008
Medicaid Provider Manual; Adult Benefits Waiver
Page 4

The plan issues a handbook to all its beneficiaries. A copy of this handbook was admitted into evidence. It contains the following relevant portion:

II-H Non-covered Services

The following services are not covered under the ABW Program through the County Health Plan nor directly through DCH: (most omitted by this ALJ)

- Inpatient Hospitalization Services-including all facility and professional services related to inpatient hospital services.

credibly established that she is seeking hernia repair surgery and that she needs it to enhance her functional status. Additionally the Appellant sought approval to have the surgery performed on an out-patient basis, however, her doctor specifically denied this request, indicating it was necessary for her to have the procedure done in-patient. While this ALJ certainly sympathizes with the Appellant's plight, her need for surgery is not the controlling material fact at issue. The coverage limitations are clearly set forth and must be adhered to. The authority of this ALJ does not extend to equity, nor policy exceptions.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find that denial of coverage for the requested surgery is appropriate, as in accord with current policy concerning coverage and limitations.

IT IS THEREFORE ORDERED that:

denial of coverage is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 1/8/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.