STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-43950 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. He had no witnesses. [redacted], customer services, represented the Medicaid Health Plan (MHP). Her witnesses were [redacted], medical director and [redacted], quality assurance director.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for TMJ services?

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 [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant has been a member of the Respondent MHP since [redacted] (Appellant's Exhibit #1)

3. The Appellant suffers from pain, anxiety, major depression, PTSD, fibromyalgia, chronic fatigue and TMJ. (Respondent's Exhibit A, p. 7 and Appellant's Exhibit #1)

4. The Appellant sought approval for a consultation at the University of Michigan regarding his TMJ. (Appellant's Exhibit #1 and Respondent's Exhibit A, p. 3)

5. Following review the request was denied as TMJ services are not covered services under Medicaid or the health plan. (See Testimony and Respondent's Exhibit A – throughout)

6. The Appellant was notified of the denial on [redacted]. His further appeal rights were contained therein. (Respondent's Exhibit A, pp. 2, 8 – 10)

7. The instant appeal for the MHP denial of TMJ service was received by SOAHR on [redacted]. (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. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor 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 2.024.

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 covered 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 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- 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)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar 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
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.

- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22.

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

[General Information]

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, … **Management** & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website….

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. … Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

SERVICES COVERED BY MEDICAID HEALTH PLANS

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) for up to 45 days
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar 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-maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

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

[1] Underscored elements indicate revision or added on July 1, 2010 edition of MPM.

NONCOVERED SERVICES

The following dental services are excluded from Medicaid coverage:

- Orthodontics, unless there is a CSHCS qualifying diagnosis
- Gold Crowns, Gold Foil Restorations, Inlay/Onlay restorations
- Fixed Bridges
- Bite Splints, Mouthguards, sports appliances
- TMJ Services
- Services or Surgeries that are experimental in nature
- Dental Devices not approved by the FDA
- Analgesia, Inhalation of Nitrous Oxide

(Emphasis supplied) MPM, Dental §7 at page 21

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The MHP witness, [redacted], testified that the Appellant's request was denied because TMJ is not a covered service under the Medicaid or the MHP. He referred to the Dental section of the Medicaid Provider Manual at section 7 for the appropriate exclusion.

Nurse [redacted]r testified that prior to hearing the MHP learned that the Appellant is a person with "multiple issues" and informed the ALJ that the MHP was assigning the Appellant a case manager to help him deal more effectively with his primary care physican, [redacted]

The Appellant testified that his was not a dental issue - and that all of those remedies have long since been exhausted. He testified that his affliction concerns "joints, muscle and ligaments." He said he was hoping for a consultation "down there" [redacted] to perhaps secure some other option.

On review, the Appellant seeks services presently excluded under Medicaid and which are not covered under this health plan. He has not preponderated his burden of proof that the MHP inappropriately denied a medically necessary request for service.

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 TMJ services.

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

cc: [redacted]

Date Mailed: 9/30/2010

***** 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.