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. 2010-45599 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] appeared on her own behalf.

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

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for surgical excision of a right leg lesion?

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], a Medicaid Health Plan (MHP).

2. The Appellant suffers from a right leg ulcer. (Exhibit 1, page 6)

3. The MHP received a [redacted], prior authorization request for excision of benign lesion of leg from the Appellant's podiatry provider, [redacted]. (Exhibit 1, page 6)

4. On [redacted], the MHP sent a request for supporting documentation to the Appellant's podiatry provider. (Exhibit 1, page 7)

5. The MHP received additional documentation from the Appellant's provider. (Exhibit 1, pages 9-15)

6. On [redacted], the MHP sent the Appellant a denial letter stating that the request for surgical excision of a right leg lesion was not authorized because the podiatry services are not a covered benefit per the Michigan Department of Community Health Medicaid Provider Manual. (Exhibit 1, pages 2-5)

7. The Appellant appealed the denial on [redacted].

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. Surgical excision of a leg lesion falls within Medicaid Provider Manual policy governing general surgery. Section 12 General Surgery states "Medicaid covers medically necessary surgical procedures." *Michigan Department of Community Health Medicaid Provider Manual; Practitioner Version Date April 1, 2010, Page 60.*

However, the Medicaid Provider Manual policy also states:

> Section 23- Podiatrist
>
> As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Podiatry services are no longer payable for beneficiaries age 21 and older unless a beneficiary has a prior

> authorization on file. Only prior authorization requests received on or before 06/30/2009 will be processed.
>
> *Michigan Department of Community Health*
> *Medicaid Provider Manual, Practitioner Section*
> *July 1, 2010, Page 95. (Exhibit 1, page 16)*

The prior authorization request indicates the planed surgery was to be performed by the Appellant's podiatry provider. (Exhibit 1, page 7) The MHP Medical Director testified that the prior authorization request was denied because the Medicaid policy does not allow for coverage of services provided by a podiatrist.

The Appellant disagrees with the denial of the requested surgery and testified that she has gangrene. The Medical Director indicated that the MHP would reconsider the requested surgery if a different type of provider was performing the service. For example a dermatologist or vascular surgeon would be appropriate for skin or vascular problems. (Medical Director Testimony)

The MHP's prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. Medicaid policy indicates that effective July 1, 2009, podiatry services are no longer payable for beneficiaries age 21 and over pursuant to Executive Order 2009-22. The MHP's denial must be upheld. The Appellant can ask the MHP for assistance in finding a different provider for the requested treatment that would be covered.

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 surgical excision of a right leg lesion 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: 10/19/2010

***** 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.