STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-4891 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] and [redacted] The Appellant/minor appeared without English speaking representation.[1] She had no witnesses. [redacted], [redacted], represented the Medicaid Health Plan (MHP). Her witness was [redacted], Director of Health Services.

The hearing was continued, without objection, when the ALJ discovered that the MHP had not been copied on Appellant's [proposed] Exhibit #1.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for a septoplasty?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in [redacted]).

[1] There was no reference to a language barrier in the Appellant's petition; however the Appellant was clearly able to speak both English and Arabic. She was instructed, with her mother's consent, to act as translator.

2. On [redacted], the MHP received a request from [redacted] for an adenoidectomy and septoplasty. (Respondent's Exhibit A, pp. 4, 5)

3. The Appellant is afflicted with nasal obstruction; allergic rhinitis, adenoid hypertrophy and deviated septum. (Respondent's Exhibit A, p. 3)

4. The surgical request was reviewed and denied as the clinical documentation failed to present a try-fail regiment or consistent pattern of medications commonly prescribed for the Appellant's affliction. (Respondent's Exhibit A, p. 1 and See Testimony of [redacted])

5. A companion request for adenoidectomy was, however, approved. (Appellant's Exhibit #1, p. 3)

6. The Appellant was notified of the denial on [redacted], she was further informed of her appeal rights. (Respondent's Exhibit A, pp. 1, 2)

7. The instant request for hearing 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 [redacted], the Department received approval from the [redacted] 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.

[redacted] 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.

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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.

Supra, Contract, §II-P p. 66

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A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. In this instance the Appellant failed to preponderate that the requested septoplasty was medically necessary - based on a lack of medical evidence.

The Department witness testified that there was no evidence of a try-fail course of treatment utilizing medications appropriate to alleviation of the Appellant's symptoms.

In fact, witness [redacted] testified that the limited documentation supplied by the Appellant showed effective results from the use of the antihistamine Neo-Synephrine.

There was no documentation on the use of other commonly used prescription medications such as daily antihistamines [for a prolonged period] or intra-nasal steroids. Even the medications referenced by the Appellant in her testimony and exhibit failed to document the success or failure on repeated use [if any] or how long the course of treatment lasted. The Appellant said it dated back six years and that her physican had merely provided her with samples of the medications; Singular, Astelin and Nasonex.

Under its contract with the Department, an [redacted] is permitted to establish medical necessity criteria. In this case the [redacted] was presented with conflicting evidence of successful results on use of medication - in the face of a request for multiple surgical procedures.[2]

Even though documentation of an "anterior deviation of the septum to the left" was provided to the [redacted], there was no evidence that the preliminary treatments had been successfully attempted or completed. The [redacted] witness urged the Appellant to coordinate her care on this issue with her primary care physican.

Based on the evidence presented today I conclude that the [redacted] has properly denied the Appellant's request for septoplasty.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the [redacted] properly denied the Appellant's request for septoplasty.

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]

[2] The surgical consultation identifies an anterior deviation and successful use of an antihistamine. Respondent's exhibit A, p. 3 and Appellant Exhibit #1, p. 4.

Date Mailed: 3/4/2010

***** 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.