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. 2010-7409 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 was represented by his mother, [redacted].

[redacted] was represented by [redacted] Manager Clinical Review Services, and [redacted], Medical Director, appeared as witnesses for [redacted]. [redacted] is a Department of Community Health contracted Medicaid Health Plan (hereinafter MHP).

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for body sock, wrist seatbands, and weighcool bracelets?

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 [redacted] Medicaid beneficiary.

2. The Appellant has been diagnosed with sensory problems with abnormal behaviors. (Exhibit 1 page 9)

3. On [redacted], a request for body sock, wrist seatbands, and weighcool bracelets was submitted to the MHP by Appellant's provider. (Exhibit 1 page 10)

4. On [redacted], the MHP sent an Adequate Action Notice to the Appellant stating that the providers request for the body sock, wrist bands, and weighcool bracelets was denied because the items are not standard durable medical equipment. The notice indicated the MHP determined these items are for recreational, fun, therapeutic and educational purposes and services that are recreational or educational in nature are not a covered Medicaid benefit. (Exhibit 1 page 15)

5. The Appellant's Internal Grievance/Appeal form was received by the State Office of Administrative Hearing and Rules for the Michigan Department of Community Health on [redacted] (Exhibit 1, page 7)

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 (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.*

Section 1.8 of the Medical Supplier portion of the Medicaid Provider Manual, as effective October 1, 2009, addresses durable medical equipment**:**

> **1.8 DURABLE MEDICAL EQUIPMENT**
>
> **1.8.A. STANDARD AND CUSTOM-MODIFIED VERSUS CUSTOM-MADE EQUIPMENT**
>
> Standard, custom-modified, or custom-made equipment must be medically necessary and meet the medical need and/or functional need of the beneficiary.

- Custom-modified or custom-fitted refers to modifications to a standard item to meet functional needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item) based on the measurement of the specific beneficiary.

- Custom-made equipment is fabricated to meet the beneficiary's specific medical and/or functional need. The item cannot be used by another beneficiary and conforms to individual measurements, body castings and/or moldings. It incorporates minimal use of prefabricated components, with the majority of the device being fabricated specifically for the beneficiary.

MDCH will consider coverage of custom-made equipment when a standard or custommodified item (commercially available) will not meet the medical and/or functional needs of the user. All custom-made equipment requires PA. Once the custom-made equipment is purchased, it becomes the property of the beneficiary.

Medicaid Provider Manual, Medical Supplier 10-1-2009 page 10.

Section 1.10 of the Medical Supplier portion of the Medicaid Provider Manual, as effective October 1, 2009, addresses items that are not covered by Medicaid. The list of "noncovereved items" includes adaptive equipment (e.g., rocker knife, swivel spoon, etc.), equipment for social or recreational purposes, exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.), sensory devices (e.g., games, toys, etc.), and therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile). Medicaid Provider Manual, Medical Supplier 10-1-2009 pgs. 14-16.

On [redacted], a request for Ablations body sock, wrist seatbands, and weighcool bracelets was submitted to the MHP by Appellant's provider. (Exhibit 1 pages 8-12) The MHP reviewed and denied the request on [redacted] stating that the requested items are not standard durable medical equipment. The MHP, based on the clinical and product information provided, determined that the items are recreational, fun, therapeutic, and educational purposes. Services that are recreational/educational in nature are not a Medicaid covered benefit. (Exhibit 1 pg. 13)

The Appellant's representative testified that she disagreed with the denial because these items help to calm the Appellant, who suffers from emotional and sensory issues. (See also Exhibit 1, page 9) The Appellant's representative agreed that the items are not durable medical equipment and are not a medical necessity. The Appellant's representative stated that the items are behavioral in nature rather than medical.

While this ALJ understands the Appellant's representative's concern for her son, it is uncontested that the requested items are not durable medical equipment. The requested items would be used as a sensory device and for therapeutic purposes. The requested items could also be considered social or recreational in nature. Accordingly, the MHP followed Medicaid policy which states that such items are not covered by Medicaid.

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 body sox, wrist seatbands, and weighcool bracelets.

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: 2/2/2010

***** 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.