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. 2010-7836 QHP
Case No. [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. She had no witnesses. [redacted], Director of Member Services represented [redacted]). Her witness was [redacted], manager and Medical Director, [redacted]

ISSUE

Did the [redacted] properly deny Appellant's request for a Hospital Bed?

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

2. The Appellant has been enrolled with [redacted] since [redacted] (Appellant's Exhibit #1)

3. The Appellant is afflicted with the residuals of multiple CVAs. (See Testimony of Appellant and Appellant's Exhibit #1)

4. On [redacted], the [redacted] received and denied a request for a hospital bed for lack of documentation supporting medical necessity. (Respondent's Exhibit A, p, 11)

5. The medical supplier in this instance is [redacted]. (Respondent's Exhibit A, pp. 8, 11)

6. The Appellant, her physican(s) and the supplier were notified of the denial on or about [redacted] (Respondent's Exhibit A, p. 11)

7. The instant request for hearing was received 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 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 [redacted].

> 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 I-Z.
>
> Article II-G, Scope of Comprehensive Benefit Package, Contract, 2008, p. 32.

> 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 utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.
>
> 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, [*See also* Medicaid Provider Manual, Medical Supplier, §§1.2; 1.6, January 1, 2010, at pages 2 and 6]

***

The [redacted] witnesses testified that there was inadequate information provided to support approval of the Appellant's requested Hospital Bed. Witness [redacted] testified that the [redacted] attempted to contact the Appellant's primary care physican for coordination and clarification without success. The request for the Hospital Bed was then reviewed and denied by [redacted] Medical Director, [redacted] – for lack of supporting documentation.

The Appellant testified that she has the bed, and that it was prescribed by "one of the hospital doctors" during her recent hospitalization for CVA. She could not recall the

name of the prescribing physican, although the prescription pad rendering appears to be [redacted]. [See Respondent Exhibit A, at page 9]

The Appellant further explained that she did not have a primary care physican at the time in question – and this was verified by the [redacted] witness confirming her discharge from practice.

The Appellant's current listed PCP of record is [redacted]. It is unknown if the Appellant participates as his patient as of the hearing date.

The Appellant testified that she needs the Hospital Bed owing to her requirement of elevation and space limitations at her post hospital recovery site. She said she has the bed.

The [redacted] witness credibly testified that there was inadequate clinical information presented for an appropriate review.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Respondent's denial of the Appellant's request for a Hospital Bed [E0294] received upon discharge from hospital was properly denied for lack of supporting clinical information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/18/2010

***** 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.