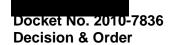
# STATE OF MICHIGAN STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH

P.O. Box 30763, Lansing, MI 48909 (877) 833-0870; Fax: (517) 334-9505

IN THE MAT	TER OF:
Appellant	,
	Docket No. 2010-7836 QHP Case No.
	DECISION AND ORDER
	s before the undersigned Administrative Law Judge pursuant to MCL 400.9 431.200 <i>et seq.</i> , upon the Appellant's request for a hearing.
appeared wi	tice, a hearing was held on thout representation. She had no witnesses.  The Appellant prices, and pri
ISSUE	
Did th Bed?	properly deny Appellant's request for a Hospital
FINDINGS C	OF FACT
	strative Law Judge, based upon the competent, material and substantial the whole record, finds as material fact:
1.	At the time of hearing the Appellant is a disabled beneficiary. (Appellant's Exhibit #1)
2.	The Appellant has been enrolled with (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 the state of the state of
- 5. The medical supplier in this instance is Exhibit A, pp. 8, 11) (Respondent's
- 6. The Appellant, her physican(s) and the supplier were notified of the denial on or about (Respondent's Exhibit A, p. 11)
- 7. The instant request for hearing was received on (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 Report of 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

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.

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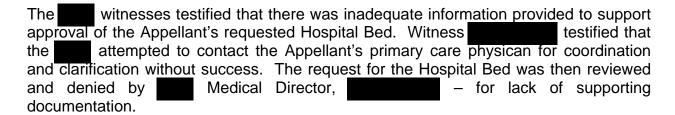
The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- 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.

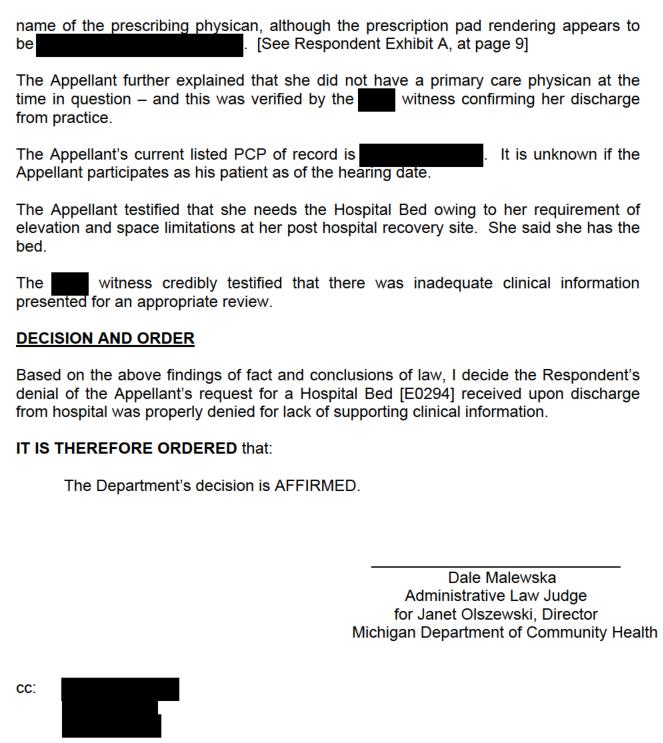
Supra, Contract, §II-P p. 66, [See also Medicaid Provider Manual, Medical Supplier, §§1.2; 1.6, January 1, 2010, at pages 2 and 6]

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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





Date Mailed: 2/18/2010

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#### \*\*\* 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.