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]

Docket No. 2011-11895 PA
Case No. 3442427

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 et seq., following the Appellant's request for a hearing.

After due Notice, a hearing was held [redacted]. [redacted] (Appellant) appeared and testified on his own behalf. Mary Carrier, Manager of the Appeals Section in the Department [redacted] represented the Department. The Department's witness was [redacted] Mapes, R.N. Analyst for the Department of Community Health.

ISSUE

Did the Department of Community Health properly deny prior authorization (coverage) for the durable medical equipment requested by the Appellant's physician?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. Appellant is enrolled in the Adult Benefit Waiver (ABW) program.

2. The Appellant seeks authorization (coverage) for a CPAP machine and equipment necessary to operate it.

3. The Appellant's physician sent a request for prior authorization for the durable medical equipment to the Department of Community Health prior authorization section.

4. The Department analyst processed the request and determined the durable medical equipment is not covered pursuant to the Department Policy, the Department analyst sent a Notice of denial to the Appellant on [redacted].

5. The Appellant appealed the denial [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 January 16, 2004, the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The new program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.
>
> **SECTION 1 – GENERAL INFORMATION**
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> This chapter applies to all providers.
>
> The Adult Benefits Waiver (ABW) provides health care benefits for Michigan's childless adult residents (age 19 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL).
>
> Covered services and maximum copayments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.
>
> **1.1 COUNTY-ADMINISTERED HEALTH PLANS**
>
> ABW beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:

- Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources.

When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable copayments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.

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The Appellant is an ABW beneficiary. As such, he is entitled to only those services afforded to ABW beneficiaries. Coverage and limitations are listed below:

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service Coverage

Ambulance Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).

Case Management Noncovered

Chiropractor Noncovered

Dental Noncovered

Emergency Department Covered per current Medicaid policy. For CHPs, PA may be required for nonemergency services provided in the Emergency Department.

Eyeglasses Noncovered

Family Planning Covered. Services may be provided through referral to local Title X designated Family Planning Program.

Hearing Aids Noncovered

Home Health Noncovered

Home Help (personal care) Noncovered

Hospice Noncovered

Inpatient Hospital Noncovered

Lab & X-Ray Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.

Medical Supplies/Durable Medical Equipment (DME) Limited coverage.

- Medical supplies are covered except for the following noncovered categories: gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item.
- DME items are noncovered except for glucose monitors.

Mental Health Services Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)

Nursing Facility Noncovered

Optometrist Noncovered

Outpatient Hospital (Nonemergency Department) Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A $3 copayment for professional services is required. *Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No copayment may be charged for family planning or pregnancy related services.

Noncovered: Therapies, labor room and partial hospitalization.

Pharmacy Covered:

- Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or oral-maxillofacial surgeon. PA may be required. Products must be billed to MDCH or CHP, as appropriate.
- Psychotropic medications are provided under the FFS benefit. (Refer to the MDCH Pharmacy Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. Refer to the Directory Appendix for website information.)

The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently.

Noncovered: Injectable drugs used in clinics or physician offices.

Copayment: $1 per prescription

Physician
Nurse Practitioner (NP)
Oral-Maxillofacial Surgeon
Medical Clinic

The following services are covered per current Medicaid policy:

- Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under the Breast and Cervical Cancer Program administered by the LHD may be referred to that program for services as appropriate.
- Diagnostic and treatment services. May refer to LHD for TB, STD, or HIV-related services, as available.
- General ophthalmological services (procedure codes 92002-92014)
- Immunizations per current Advisory Committee on Immunization Practices (ACIP) guidelines. May be referred to LHD. Travel immunizations are excluded.
- Injections administered in a physician's office per current Medicaid policy. CHPs may require PA for some injections. Specific psychotropic injectable drugs administered through a PIHP/CMHSP clinic to an ABW beneficiary are reimbursed by MDCH on a fee-for-service basis when the following criteria is met:
    - The beneficiary has an open case with the PIHP/CMHSP; and

- The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/support regimen; and
- The PIHP/CMHSP physician has determined that the beneficiary may not comply with the medication regimen if the injections were not administered through the PIHP/CMHSP clinic and that this non-compliance could adversely affect the beneficiary; and
- The PIHP/CMHSP clinic notifies the beneficiary's CHP or primary care physician that this service is being rendered; or
- The injectable drug is listed on the MH/CHP/SA (PIHP/CMHSP/Children's Waiver) Injectable Drugs Billable to MDCH database.

Injectables that do not meet the above criteria remain the responsibility of the CHP, and the CHP's prior authorization requirements must be followed.

The specific injectable drugs are only covered by MDCH through fee-for-service basis **if** provided by a physician as part of his affiliation with a PIHP/CMHSP and must be billed using the NPI number associated with the PIHP/CMHSP. Payments made to a physician for injectable drugs administered to an ABW beneficiary that are not billed under the NPI number not associated with a PIHP/CMHSP physician group will be subject to recovery.

- Services performed by oral-maxillofacial surgeons are covered under the current identified on the Oral-Maxillofacial Surgeon database, performed by oralmaxillofacial surgeons are only covered for the relief of pain and/or infection.

PA may be required for some services. A $3 copayment is required for office visits (professional services). *Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No copayment may be charged for family planning or pregnancy related services.

Noncovered: Services provided in an inpatient hospital setting.

Podiatrist Noncovered

Orthotics Noncovered

Private Duty Nursing Noncovered

Substance Abuse Covered through the Prepaid Inpatient Health Plan (PIHP). (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)

Therapies Occupational, physical, and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting.

Transportation (nonambulance) Noncovered

Urgent Care Clinic Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator. A $3 copayment is required. *Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No copayment may be charged for family planning or pregnancy related services.

Service Coverage Prosthetics/Orthotics Noncovered

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[redacted] credibly established that he is seeking medically necessary durable medical equipment. He requires a CPAP machine and accompanying accessories to address his severe sleep apnea. Unfortunately the coverage provided by his medical program does not include durable medical equipment, even if it is medically necessary, with the sole exception being a glucometer. This ALJ is concerned for the health of the Appellant, however, has no authority to order the Department to provide the medically necessary equipment. The coverage limitations are clearly set forth and must be adhered to. The authority of this ALJ does not extend to equity, nor policy exceptions.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Department of Community Health followed its own policy when it denied coverage for the durable medical equipment.

IT IS THEREFORE ORDERED that:

The Department of Community Health's denial of coverage is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/10/2011

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.