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. 2011-12093 ABW
Case No. 16710688

Appellant
_____/

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 appealing the Department's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. She had no witnesses. [redacted], Department Manager, represented [redacted].

Also in attendance observing, but not testifying, was [redacted].

ISSUE

Did the Department properly deny Appellant's request for transportation services?

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 enrolled in the [redacted] as an Adult Benefit Waiver beneficiary.

2. The CHP contracts with [redacted] to provide services covered by the Adult Benefit Waiver.

3. Appellant is [redacted].

4. According to the Appellant's representative they are trying to get the Appellant "back on disability." She said that Appellant requires a great deal of assistance with bathing, medication management, toileting and

DME needs. See Testimony of [redacted] and Appellant's Exhibit #1.

5. On [redacted], the [redacted] sent the Appellant a notice of denial of services stating that, "NON-AMBULANCE Transportation is a non-covered service under the ABW program in the state of Michigan." Department's Exhibit A, pp. 1-8.

6. On [redacted], the State Office of Administrative Rules received the instant request for an Administrative Hearing.

CONCLUSIONS OF LAW

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 program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.

The Department's policy with regard to the Adult Benefits Waiver is found in the Medicaid Provider Manual (MPM):

> **[ ] 1 – GENERAL INFORMATION**
>
> 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.
>
> The Michigan Department of Human Services (MDHS) may also refer to the ABW as the Adult Medical Program.
>
> **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.
>
> 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.
>
> MPM, Adult Benefits Waiver, January 1, 2011, p. 1.

A review of the Medicaid Provider Manual demonstrates that non-ambulance transportation is not a covered benefit under the Adult Benefits Waiver. Section 2 of the Medicaid Provider Manual, Adult Benefits Waiver chapter, provides in pertinent part.

> **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.

Service Coverage 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. *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 carve out 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.

- Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. [omitted by ALJ] No copayment may

be charged for family planning or pregnancy related services.

Service Coverage

- 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 Medicaid physician benefit. Limited emergent/urgent dental procedures, as 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). [* omitted by ALJ]

Noncovered: Services provided in an inpatient hospital setting.

Podiatrist Noncovered

Service Coverage Prosthetics/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. [omitted by ALJ]

MPM, *Supra* pp. 4-7.

***

The Appellant's representative testified that she understood that transportation was an excluded service – but that her main desire was to get her [redacted] "back on disability." The limitations of the ABW program were explained to the representative on the record.

The Department witness testified credibly that transportation – as requested by the Appellant - was an excluded service under the ABW in Michigan.

If the Appellant desires information regarding other public health benefits programs for which she may be eligible and for which she may engage in a benefit's program application process, she may do so by contacting her Department of Human Services Eligibility Specialist case worker.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the [redacted] properly denied Appellant's request for non-ambulance related transportation services.

IT IS **THEREFORE ORDERED** THAT:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/25/2011

***** 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.