STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-18644 ABW
Case No. [redacted]

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.

After due notice, a hearing was held on [redacted]. [redacted] appeared on his own behalf. [redacted] represented [redacted], a County-Administered Health Plan (CHP).

ISSUE

Did the County Health Plan properly deny Appellant's prior authorization requests for a CPAP machine for sleep apnea, Cialis medication covered with only a $1.00 co-pay, and chiropractor 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 County Health Plan as an Adult Benefit Waiver beneficiary.

2. The CHP contracts with the County Health Plan to provide services covered by the Adult Benefits Waiver.

3. Appellant is a [redacted] male.

4. In [redacted] Appellant had a sleep apnea test performed which revealed he had severe obstructive sleep apnea. (Exhibit 3, pp 4-6).

5. On [redacted], Appellant's physician, [redacted], wrote a prescription for a CPAP machine for sleep apnea for Appellant. (Exhibit 3, p 8).

6. On or after [redacted], Appellant requested a CPAP machine for sleep apnea, Cialis medication covered with only a $1.00 co-pay, and chiropractor

services. (Exhibit 3).

7. After [redacted], the Health Plan reviewed the Appellant's requests along with the medical documentation it had, and denied the requests because the CPAP machine for sleep apnea, Cialis for erectile dysfunction, and chiropractic services are not covered services under the ABW waiver. (Exhibit 1).

8. On [redacted], the Department of Community Health (DCH) received the Appellant's request for an Administrative Hearing. (Exhibit 2).

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:

> **SECTION 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 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments 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.
>
> **SECTION 1.1 - COUNTY ADMINISTERED HEALTH PLANS**
>
> ABW beneficiaries enrolled in 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 as 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.

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. *

- 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

Medicaid Provider Manual, Adult Benefits Waiver, April 1, 2011, Pages 4-5.

CPAP machine and chiropractor services-

The Appellant testified at hearing that he had a prescription from his doctor for a CPAP machine. This Administrative Law Judge allowed the Appellant an opportunity to submit the prescription and other medical documentation from his physician. The documents included a printout of previous chiropractor visits. (Exhibit 3).

The CHP representative stated that it implements the ABW program consistent with Department Medicaid policy. The CHP representative testified and submitted evidence that its coverage policy is consistent with the Department's Medicaid policy which explicitly excludes coverage of a CPAP machine because it is durable medical equipment and durable medical equipment is not covered. (Exhibit 1, pages 2-3). The CHP representative also testified and submitted evidence that its coverage policy explicitly excludes coverage of chiropractor services. (Exhibit 1, page 2). The CHP established that a CPAP machine and chiropractic services are not covered services under the ABW waiver. (Exhibit 1, attachments C, D and F).

Cialis coverage-

The Appellant testified that the Cialis medication he requested was for erectile dysfunction. The CHP representative explained that while the ABW program covered some medications, it was prohibited from covering those medications that Medicaid does not cover. The CHP representative testified that erectile dysfunction medication is not covered under Michigan Medicaid and that the ABW program is prohibited from covering it. The CHP representative explained that Cialis' generic may be covered if there is a documented need for a need to treat a cardio-vascular condition, but he requested Appellant's medical records, reviewed the medical records, and there was no medical documentation from Appellant's doctor of a request to treat a cardio-vascular problem with Cialis. The CHP established that the Cialis requested was not a Medicaid covered medication.

The Appellant citied several state and federal laws, including the Americans with Disabilities Act and requested that this Administrative Law Judge law judge over-rule the ABW program's denial of at least two of the three requested services.

The CHP denial of CPAP machine, chiropractor services, and Cialis is consistent with Medicaid policy. The CHP and this Administrative Law Judge is bound by Department Medicaid policy, and neither can over-rule state and federal law and policy. As such, the CHP is not required to provide coverage for a CPAP machine, chiropractor services, and Cialis. For these reasons the CHP's denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the County Health Plan properly denied Appellant's CPAP machine, chiropractor services, and Cialis requests.

IT IS **THEREFORE ORDERED** THAT:

The County Health Plan's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/12/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.