**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]

Appellant
_____/

Docket No. 2011- 23909 ABW
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. He had no witnesses. [redacted], represented the Department. She had no witnesses.

## ISSUE

Did the Department properly deny the Appellant's request for a C-Pap machine?

## 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 county health plan contracts with the Department to provide services covered by the Adult Benefit Waiver.

3. Appellant is a [redacted] year-old male.

4. The Appellant testified that he needs a C-Pap machine for treatment of blood clots in his right leg area. See Testimony.

5. The Appellant also testified that he thought this hearing was to determine eligibility for Medicaid.

6. The Appellant was advised that this was not a Medicaid eligibility hearing – nevertheless he expressed his desire to pursue his appeal before this tribunal. See Testimony.

7. On [redacted], the Michigan Administrative Hearing System for the Department of Community Health received the instant request for an Administrative Hearing. (Appellant's Exhibit #1)

## 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 testified that he thought this hearing was to obtain Medicaid eligibility so he could enhance his coverage for medical treatment at the University of Michigan where he is presently undergoing serious medical treatment. He also explained that he has a medical need for a C-Pap machine beyond the obvious sleep assistance such a device provides.

The limitations of the ABW program were explained to the Appellant on the record by representative Carrier.

The Department witness testified credibly that durable medical equipment (DME) such as a C-Pap machine is not a covered service under the Adult Beneficiary Waiver program and that the only covered DME item was a blood glucose monitor.

The Appellant was instructed on the process for application [or hearing] before his Department of Human Services Eligibility Specialist case worker.

Having not withdrawn his appeal before this tribunal the Appellant has failed to preponderate his burden of proof that the Department erred in the denial of his request for a C-Pap machine. The Department properly explained that this was a noncovered item under policy. The Department's denial was proper when made.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for a C-Pap machine.

[redacted]
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**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: 5/27/2011

***** 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.