STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2011-27518 QHP
Case No. 38686990

[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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], was present for the hearing. The Respondent, [redacted] Healthcare of Michigan, was represented by [redacted], Appeals Coordinator. Dr. [redacted], Medical Director, appeared as a witness for the Respondent.

ISSUE

Did the Respondent properly deny the Appellant's request for a garment belt sleeve orthotic?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Respondent, [redacted] Healthcare of Michigan, is a Michigan Department of Community Health (MDCH) contracted Medicaid Health Plan (MHP).

2. The Appellant is a[redacted]-year-old Medicaid beneficiary, who is enrolled in the Respondent MHP.

3. The Appellant has been diagnosed with patello-femoral syndrome. (Exhibit 1, page 13)

4. On [redacted], the MHP received a request for coverage of a garment belt sleeve orthotic for the Appellant. The request included a billing code of A[redacted]. (Exhibit 1, page 12-13)

5. On [redacted], the MHP sent the Appellant notice that the request for a garment belt sleeve orthotic was denied because, pursuant to Department policy, the requested billing code for the therapy is not a covered benefit. (Exhibit 1, pages 2-5)

6. On [redacted], the Department received the Appellant's Request for Hearing.

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 May 30, 1997, 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 Medicaid Health Plans.

> 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. The Contractor 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 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
>
> (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
> (e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.
>
> (2) Prior Approval Policy and Procedure
> The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Section 1.022(AA), Utilization Management, Contract, October 1, 2009.*

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." However, Medicaid Provider Manual states that the "MHPs may also choose to provide services over and above those specified." *MDCH Medicaid Provider Manual, Health Plan, Version Date: January 1, 2011, page 1.*

The MHP explained that it denied the Appellant's request for a garment belt sleeve orthotic because it was bound to follow Medicaid policy, which does not specifically provide coverage for the code requested in its databases. The MHP's medical director

stated that even though the requested garment belt sleeve orthotic is medically necessary, the MHP cannot provide it because it is not a covered benefit.

The Centers for Medicare and Medicaid Service (CMS) has advised that insurers cannot make coverage determinations based on procedure codes. *CMS Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures.* Indeed, the database printout from the Medicaid Provider Manual that the MHP refers to in support of its decision in this case specifically states that it "is not a source for Medicaid coverage policy." (Exhibit 1, page 8). Therefore, The MHP's position is without merit.

Medicaid beneficiaries are entitled to medically necessary Medicaid-covered services. *See 42 CFR 440.230.* When the MHP's medical director determined that the requested item was medically necessary, it should have been approved.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the Medicaid Health Plan improperly denied the Appellant's request for a garment belt sleeve orthotic.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

[redacted]
Administrative Law Judge
for Janet Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/31/2011

***** 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.