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. 2011-29555 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. Her witness was [redacted]. [redacted] represented the Department. She had no witnesses.

ISSUE

Did the Department properly deny the Appellant's request for dental 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 county health plan contracts with the Department to provide services covered by the Adult Benefit Waiver.
3. Appellant is a [redacted] year-old female.
4. The Appellant and her witness testified that she needs "pills" referrals and an ENT.
5. She said she went to the emergency room and received referrals – which she returned to the hospital. See Testimony.
6. The Appellant was notified of the [redacted] denial on [redacted]. Her further appeal rights were contained therein. Department's Exhibit A, p. 1.

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.

… [omitted by ALJ]

MPM, *Supra* pp. 4-7.

***

The Appellant testified that she needed "nerve pills" and treatment for inflammation and that she had referrals following her emergency room visit – but that she returned them, [including her Xanax], to the hospital because she, "couldn't use them."

The Appellant identified her primary care physican as [redacted] – while the Department witness said her primary care physican was [redacted]. The Department witness explained

that dental services are not a covered benefit and that any referrals sought must be placed within the health plan network – and may require prior authorization.

The Appellant said she has contacted Community Mental Health for assistance.

The Appellant was advised by the Department representative that her primary care physican was [redacted] [not [redacted]] and that any referrals had to stay "in network" as the [redacted] has no record of any referral for the Appellant.

Dental service is not a covered benefit under the Adult Benefit Waiver and the ALJ has no authority "to change the Appellant's insurance." The Department properly explained that this was a non-covered service 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 Dental services as a non-covered item under policy.

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: 7/13/2011

***** 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.