STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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. 2011-1582 QHP
Case No. 27088621

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. The Appellant represented herself at hearing.

[redacted] was represented by [redacted]. [redacted] was present and provided testimony.

ISSUE

Did the Plan properly deny the Appellant's request for a glucose monitoring system?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. The Appellant is [redacted] Medicaid beneficiary. (uncontested)

2. The Appellant's physician requested prior authorization for a continuous glucose monitoring system on [redacted]. (uncontested)

3. The [redacted] Medical Director reviewed the request for prior authorization.

4. The Medical Director determined the request was not a covered benefit under the [redacted] evidence of coverage guidelines.

5. A Notice was sent to the Appellant and her medical provider notified of the

denial and reasons therefore on or about [redacted]. The Notice specifically informed the Appellant the request was not a covered benefit and that the requested glucose monitoring kit with the billing codes provided were not found within the Michigan Department of Community Health Medical Supplier, Orthotics, Prosthetics and DME database, therefore was not a covered benefit.

6. The Appellant appealed the denial on or about [redacted].

7. Blood Glucose testing strips are a covered benefit for the Appellant. (uncontested).

8. The Appellant has uncontrolled type I Diabetes. She uses an insulin pump.

9. The Appellant is able to check her insulin level manually 5-12 times per day. (testimony of Appellant)

10. The Appellant does not adjust her own insulin levels delivered by the insulin pump. (testimony of Appellant)

11. The Appellant's physician determines and adjusts the rate of insulin delivery from the pump used by the Appellant. (testimony of Appellant)

12. Use of a continuous glucose monitoring kit would not change how the Appellant's insulin is delivered, nor eliminate the need for her to prick her finger and check her blood sugar daily. (testimony of [redacted])

13. The Appellant's doctor would have over 500 data points indicating her glucose levels if the continuous glucose monitoring kit were used.

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.*

As it says in the above Department - MHP contract language, a MHP such as [redacted] may limit services to those that are medically necessary and that are consistent with applicable Medicaid Provider Manuals. It may require prior authorization for certain procedures. The process must be consistent with the Medicaid Provider Manual. The pertinent sections of the Medicaid Provider Manual criteria for prior authorization and Medical Necessity are below:

> **1.10 PRIOR AUTHORIZATION**
> Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:
>
> - Procedures identified as requiring PA on the procedure code databases on the MDCH website;
> - Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
> - Referrals for elective services by out-of-state nonenrolled providers.
>
> Medicaid Provider Manual
> Version Practitioner
> Date: July 1, 2009 Page 4

1.5 MEDICAL NECESSITY

Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

Medicaid Provider Manual
Version Medical Supplier
Date: July 1, 2009 Page 3

The MHP stated the denial was based upon lack of recognized billing codes within the Michigan Department of Community Health database for the items requested. The Notice sent the Appellant specifically states that the codes submitted for the items requested are not contained within the database, therefore, the items are not a covered benefit. The database referred to actually states that it is not to be used to make coverage determinations. This ALJ cannot rely on the lack of a billing code within a database to make a determination the health plan's denial was appropriate for this beneficiary. The coverage determination must be based upon medical necessity in accordance with Medicaid standards.

The Appellant provided testimony concerning her uncontrolled type I diabetes and history of hospitalization in [redacted]. She stated she can only manually check her own blood sugar 5-12 times per day but the system requested is a continuous glucose monitoring system that will provide her doctor over 500 data points per day. She further stated she uses an insulin pump and when asked indicated she does not adjust the amount of insulin delivered by the pump each day. She stated she visits her doctor monthly and s/he adjusts the pump if necessary.

The Medical Director for [redacted] testified that use of the continuous glucose monitoring system will not impact how the Appellant treats her disease each day. It will not eliminate the need to prick her finger and check her blood sugar daily.

Additionally, since her doctor adjusts the insulin pump, if necessary, use of the system would not impact how or how much insulin is delivered each day, thus the requested equipment is not medically necessary.

This ALJ reviewed the request for the continuous glucose monitoring system and accompanying documentation. The testimony from the Appellant and the Health Plan was reviewed and considered very carefully. The Appellant has the burden to establish the requested medical supplies/equipment is medically necessary. In this case, while it is undisputed the Appellant has uncontrolled diabetes, it is not evident how the requested equipment addresses that. While the Health Plan asserts nothing would change for the Appellant if she had the equipment requested because she would still have to prick her finger daily and she does not adjust her own insulin delivery, this ALJ considered the Appellant's doctor may be better able to determine the proper course of treatment and gain control of the disease with more data. However, given the evidence of record, that conclusion is speculative. There was no evidence presented that can support that conclusion. There was no testimony establishing more data is needed to properly determine the insulin levels needed to treat the Appellant's diabetes. The evidence of record does not establish why the Appellant's doctor requires more data. The evidence of record does not establish why the equipment is medically necessary to provide effective treatment for the Appellant's medical condition, thus she did not meet her burden of proof.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Department's denial of coverage for a continuous glucose monitoring system in accord with the applicable portion of the Medicaid Provider Manual.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/5/2011

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.