

**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:

██████████,

Appellant.

\_\_\_\_\_ /

Docket No. 2011-51489 QHP  
Case No. ██████████

**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 ██████████. The Appellant appeared and testified. She had a representative, ██████████, who appeared and testified.

██████████ appeared on behalf of ██████████, a Department of Community Health contracted Medicaid provider. ██████████, Chief Medical Officer for ██████████ of Michigan appeared on behalf of the plan.

**ISSUE**

Did the Department properly deny the Appellant's prior-authorization request for binaural hearing aids?

**FINDINGS OF FACT**

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

1. The Appellant is a Medicaid beneficiary enrolled with ██████████
2. The Appellant has a medical need for binaural hearing aids. (Exhibit A, pages 10-12)
3. ██████████ sought prior authorization of binaural hearing aids on the Appellant's behalf on or about ██████████
4. ██████████ reviewed the requested medical equipment and denied the request ██████████, citing internal and Medicaid policy.

5. On ██████████, the Michigan Administrative Hearing System received a hearing request.

### **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)(1) and (2),  
Utilization Management, Contract,  
October 1, 2009.*

As it says in the above Department - MHP contract language, a MHP such as Molina Health Care 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 section of the Medicaid Provider Manual criteria for Medical Necessity is below.

The Medicaid Provider Manual provides, in pertinent part, as follows:

**1.5 MEDICAL NECESSITY**

Medical devices 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. The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type

and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDCH standards of coverage. Medical equipment may be determined to be medically necessary when all of the following apply:

- 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, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- 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.
- It is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order.
- It meets the standards of coverage published by MDCH.
- It meets the definition of Durable Medical Equipment (DME), as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

### **1.10 NONCOVERED ITEMS**

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Devices used for play, pre-mobility development, or exercise are not considered pediatric mobility devices for the purpose of reimbursement and are not covered (e.g., jet mobile, ready racer, creepster crawler)
- Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Equipment for social or recreational purposes
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Hand/body wash
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Ice packs
- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g., insulin pump)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional formula representing only a liquid form of food
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Peri-wash

- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- Room dehumidifiers
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second units for school use
- Second wheelchair for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formula
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Thickeners for foods or liquids (e.g., Thick – it)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- Ultrasonic osteogenesis stimulators
- UV lighting for Seasonal Affective Disorder
- Vacu-brush toothbrushes
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

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The July 1, 2011, version of the Medicaid Provider Manual, in effect at the time of the request for prior authorization, contains reference to Executive Order 2009-022. This Executive Order is effective for service dates on or after July 1, 2009, and states that hearing aids are no longer payable for beneficiaries age 21 and older.

The hearing aids are a non-covered item according to the Medicaid Provider Manual policy set forth above. The Executive Order referenced in the Medicaid Provider Manual Chapter for Hearing Aid Dealers is binding authority in this case. Despite the medical necessity of the requested binaural hearing aids, this ALJ has no authority to make an exception for the Appellant. [REDACTED] is not required to provide coverage for items excluded by Medicaid Policy under its contract.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the denial of the Appellant's request for prior-authorization for the binaural hearing aids was supported by Medicaid Policy.

**IT IS THEREFORE ORDERED** that:

The QHP's decision is **AFFIRMED**.

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Jennifer Isiogu  
Administrative Law Judge  
for Olga Dazzo, Director  
Michigan Department of Community Health

cc:



Date Mailed: 11/17/2011

**\*\*\* 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.