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:

Docket No. 2012-41260 QHP

[redacted] [redacted] [redacted]

Appellant.
_____/

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 appeared and testified on her own behalf.

[redacted] appeared on behalf of [redacted] Health Care, a Department of Community Health contracted Medicaid provider. Dr. [redacted], Chief Medical Officer for [redacted] Health Care of Michigan was present.

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for eyeglasses?

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 Molina Health Care of Michigan.

2. The Appellant has a medical need for eyeglasses.

3. The Appellant sought prior authorization of eyeglasses.

4. [redacted] Health Care of Michigan reviewed the request for eyeglasses and informed the Appellant that coverage for eyeglasses was rescinded by Executive Order [redacted], effective [redacted].

5. Some coverage for low vision services was restored via Public Act 187 of 2010. Specific coverage codes are covered as listed in a MDCH vision services database.

6. On [redacted] 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 [redacted] 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.

The issue in this case is whether the Department properly denied Appellant's request for prior authorization for eye glasses (lenses and frame). Executive Order 2009-22, effective July 1, 2009 states:

> Vision services (routine eye exams, refractions, eyeglasses, contact lenses and other vision supplies and associated services) are no longer payable for beneficiaries age 21 and older. Eye exams and other vision services related to eye injury or eye disease will be covered.

Later, Public Act 187 of 201 was enacted, effective October 1, 2010. It states in pertinent part:

> Effective for dates of service after October 1, 2011, MDCH is reinstating coverage for low-vision services. This includes: low vision eyeglasses, contact lenses, optical devices and other related low-vision supplies and services for Medicaid beneficiaries age 21 and older.
>
> Routine eye exams, eyeglasses, contact lenses and other vision supplies and services will not be covered. Vision services relating to eye trauma and eye disease continue to be covered.
>
> A $2.00 co-pay may be required for Medicaid beneficiaries age 21 and older for:
>
> - Each separately reimbursable vision service performed by an optometrist.
> - Each dispensing service for glasses or contact lenses billed by a dispensing ophthalmologist or optometrist.
>
> Claims for low-vision services must be supported by a diagnosis code from Table 1. When billing the codes for low-vision services (as listed in Table 2) one of the diagnosis codes (as listed in Table 1) must be designated as the primary diagnosis code on the claim service lien.
>
> The codes contained in the aforementioned table include 368.46; 368.47; 369.01; 369.04; 369.06; 369.07; 369.08; 369.12; 369.13; 369.14; 369.16; 369.17; 369.18; 369.22; 369.24; 369.25. The codes submitted by the shoreline vision services included V2020 and V2203. Neither code indicates the diagnosis of low vision, thus they are excluded form coverage under the policy bulletin.

The Executive Order cited by [redacted] Health care as prohibiting coverage for eyeglasses was partially rescinded by Public Act 187 of 2010. However, there is still no coverage for routine eye exams and eyeglasses, unless it is part of the low vision services. The coverage codes that are covered are specifically listed above. The Appellant did not introduce any evidence she was seeking authorization for coverage of low vision services as identified in Public Act 187 of 2010, thus there is no basis to reverse the denial at this time. Should the coverage sought fall within low vision services which are covered (one of the specifically identified diagnosis codes) the Appellant may seek coverage with more specific information from her prospective provider. She is free to seek coverage at any time.

The Executive Order referenced in the Medicaid Provider Manual Chapter for Vision Services is binding authority in this case. Despite the medical necessity of the requested eyeglasses, this ALJ has no authority to make an exception for the Appellant. [redacted] Health Care is not required to provide coverage for item 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 eyeglasses was supported by Medicaid Policy.

IT IS THEREFORE ORDERED that:

The QHP's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 6-6-12

***** 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.