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],

Docket No. 2012-50455 QHP
Case No. [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. He had no witnesses. [redacted], Medicaid Liaison, represented the Medicaid Health Plan (MHP). Her witnesses were, [redacted], Director of Health Care and [redacted], Appeals Coordinator.

PRELIMINARY MATTER

The Respondent's [redacted] was renumbered by the ALJ owing to pagination error – as submitted.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for nutritional counseling?

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, Midwest Health Plan, is a Michigan Department of Community Health (MDCH) contracted Medicaid Health Plan (MHP).

2. At the time of hearing the Appellant is a Medicaid beneficiary enrolled in the Respondent MHP since [redacted]. [redacted]

3. The Appellant has been diagnosed with Stage 4 Renal Failure and was referred by his primary care physican for Dietician Consultation – denied by the MHP. [redacted]

4. On [redacted] the MHP received a request for coverage of a Dietician Consultation. "Nutritional Counseling" was denied as a non-covered service. [redacted]

5. On [redacted], the MHP sent the Appellant notice that the request for "Nutritional Counseling" was reviewed and denied as a non-covered benefit because "…code 97802 medical nutrition therapy is not listed therefor [SIC] this service is not a covered benefit." [redacted]

6. The Appellant's further rights on appeal were contained in the written denial. [redacted]

7. On [redacted], the Michigan Administrative Hearing System for the Department of Community Health 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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care

- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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.
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> ***
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> Contract, *Supra,* p. 49.

As stated in its Contract, the MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." However, the Medicaid Provider Manual (MPM) also states that the "MHPs may choose to provide services over and above those specified." *See* MPM, [MHP] April 1, 2012, page 1.

The MHP witness explained that it denied the Appellant's request for "Nutritional Consultation" because it was "not a covered benefit code and because the MHP determined that the Appellant's primary care physican could provide the required service."

The Appellant testified that he had requested his medical team to send supporting documentation to the MHP – which was neither received nor reviewed by Midwest.

Owing to the significance of his malady the Appellant testified that he seeks a specialist's assistance – although he testified that the service he seeks is a weight reduction issue. He testified he is unable to lose necessary weight without some medical assistance.[1]

On review, code based decisions to deny are prohibited.[2] The MHP must follow the Medicaid Provider Manual and the Contract - it was not clear based on the limited documentation presented at hearing whether the Appellant was seeking medically necessary weight loss services – or something else. The Appellant had a lack of supporting medical documentation.

[1] He testified that he is 30-35 pounds overweight and is unable to reduce on his own.

[2] 42 CFR 414.40

The Appellant voiced his intention to file another appeal with supporting medical evidence – but he declined to withdraw the instant appeal.

Medicaid beneficiaries are entitled to medically necessary Medicaid-covered services. 42 CFR 440.230. However, the Appellant must preponderate his burden of proof – which in this instance he has failed to do.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied the Appellant's request for a Dietician Consultation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]

Date Mailed: 6-19-2012

***** 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 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.