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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-8026 PAC
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]. [redacted], mother, represented the Appellant. [redacted], Appeals Review Officer, represented the Department. Dr. [redacted], Medical Consultant, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for blood test for developmental delays/genetics?

FINDINGS OF FACT

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

1. The Appellant is a [redacted]-year old Medicaid beneficiary. (Exhibit 1, page 5)

2. On [redacted], the Department received a prior approval request for blood test for developmental delays/genetics, DNA extraction from the Appellant's doctor. (Exhibit 1, pages 35-43)

3. On [redacted], the Department requested additional information from the Appellant's doctor. Specifically, what problems the Appellant is having that would be helped by the genetic testing and why the Appellant is on Sinemet. The Department also requested a history and physical and the results of the testing and consults already ordered. (Exhibit 1, page 34)

4. On [redacted], the Appellant's doctor submitted additional

documentation. The cover letter indicated the labs were drawn on [redacted] and sent to the [redacted] clinic. Retro-active authorization for the tests was requested. (Exhibit 1, pages 45-53)

5. On [redacted], the Department requested additional information from the Appellant's doctor. Specifically, to address how the plan of care is dependant on the genetic testing results. (Exhibit 1, page 44)

6. On [redacted], the Department received a prior approval request for blood test for developmental delays/genetics, DNA extraction, noting whole genome DNA extraction, from the Appellant's doctor. (Exhibit 1, pages 10-33)

7. On [redacted], the Department issued a Notification of Denial to the Appellant stating the prior authorization request for blood test for developmental delays/genetics was denied because medical necessity was not established. Specifically, the results of the testing do not appear to significantly impact the treatment and the suggested exam for mental retardation has not been done. Additionally, CHSCS can not consider requests from primary care providers, all requests must be from subspecialists. (Exhibit 1, page 8)

8. On [redacted], the Michigan Administrative Hearing System received the Appellant's hearing request. (Exhibit 1, page 4)

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.

The Medicaid Provider Manual addresses medical necessity, prior authorization, laboratory testing and noncovered services:

SECTION 1 – GENERAL INFORMATION

This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons, Doctors of Podiatric Medicine (DPM), Medical Clinics, Physical Therapists (PTs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Anesthesiologist Assistants (AAs), and Nurse Practitioners (NPs).

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. The services

addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

Information is included to assist the practitioner in determining how the Michigan Department of Community Health (MDCH) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the MDCH Practitioner and Medical Clinic Database and other related procedure databases located on the MDCH website. (Refer to the Directory Appendix for website information.)

MDCH Medicaid Provider Manual,
Practitioner Section,
April 1, 2012, page 1

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.

1.10.A. TO OBTAIN PRIOR AUTHORIZATION

Providers must submit a letter to the MDCH Program Review Division to obtain PA. (Refer to the Directory Appendix for contact information.) The letter and materials submitted requesting PA must include:

- Beneficiary's name and Medicaid ID number.
- Provider's name, address, NPI number.
- Contact person and phone number.
- A complete description, including Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes as appropriate, of the procedure(s) that will be performed.

- The beneficiary's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

MDCH Medicaid Provider Manual,
Practitioner Section,
April 1, 2012, page 4

4.14 LABORATORY

Medicaid covers medically necessary laboratory tests needed to diagnose or treat a specific condition, illness, or injury. Medicaid also covers screenings such as Pap smears, PSA, TB, etc. A physician, podiatrist, dentist, or CNM must order laboratory services according to their scope of practice.

The ordering physician or CNM must document required laboratory testing in the beneficiary's medical chart regardless of where the tests are performed. The ordering physician is held responsible if he orders excessive or unnecessary laboratory tests regardless of who actually renders the services. He may be subject to any corrective action related to these services, including recovery of funds.

Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

4.14.A. MEDICAL NECESSITY

The documentation of medical necessity must include a description of the beneficiary's symptomatology and other findings that have led the physician to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity.

MDCH Medicaid Provider Manual,
Practitioner Section,
April 1, 2012, pages 31-32

8.3 NONCOVERED SERVICES [CHANGE MADE 4/1/12]

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- Experimental/investigational drugs, biological agents, procedures, devices or equipment
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports **(added 4/1/12)**

MDCH Medicaid Provider Manual,
General Information for Providers Section,
April 1, 2012, page 15

In the present case, the Department's Medical Consultant explained that the information in the three submissions for the Appellant's prior authorization request for blood test for developmental delays/genetics did not establish medical necessity. The submitted information indicates the possibility of Segawa syndrome. (Exhibit 1, page 11) The Medical Consultant's testimony and the letter from the Appellant's doctor both indicate other testifying is available for Segawa syndrome, which is also called dopa-responsive dystonia. (Exhibit 1, page 11; Medical Consultant Testimony) The submitted information indicated the doctor wants to establish whether or not the Appellant has a dopa-responsive dystonia. This would affect whether or not the Appellant remains on Sinemet, or, if this medication will be discontinued and the Appellant would start intensive treatment through Community Mental Health, which this doctor has been advocating for over several months. (Exhibit 1, page 11) Otherwise, it does not appear that the submitted information addressed how the results of this testing would affect the treatment options for the Appellant. Further, the third submission indicates the prior authorization request is for whole genome DNA extraction. (Exhibit 1, page 9) The Medical Consultant explained that the requested whole genome test is very broad and provides so much information, yet only a small portion of this information can be interpreted at this time. Accordingly, the Department denied the Appellant's prior authorization request. (Medical Consultant Testimony)

The Appellant's mother disagrees with the denial. Her testimony indicated she believed the testing was already completed and the result was negative. The Appellant's mother was unaware that the requested testing had been denied. Rather, she had been told that it was approved by the doctor's office. (Mother Testimony)

It is unclear if the requested genetic testing has already been completed. The doctor noted that the blood was drawn [redacted] and sent to the [redacted] clinic. (Exhibit 1, page 45) The first submissions indicate blood testing for developmental delays/genetic, DNA extraction. The third submission notes the requested testing was for whole genome DNA extraction. (Exhibit 1, page 9) The Appellant's mother indicated the testing was completed and the result came back negative. (Mother Testimony) A test result of "negative" is not consistent with the type of test result for whole genome sequencing analysis. It is possible that blood was drawn for multiple tests, some test other than who genome sequencing came back with a negative result, and they are still awaiting prior authorization to complete the whole genome testing. The Medical Consultant stated blood could have been drawn at the same time for multiple tests and it can be kept for quite some time for the whole genome sequencing test. (Medical Consultant Testimony)

The Medicaid Provider Manual section for Laboratory testing indicates Medicaid covers only those medically necessary laboratory tests needed for diagnosis or treatment of the beneficiaries specific condition. The Department provided sufficient evidence to support the denial of the Appellant's prior authorization request for blood test for developmental delays/genetics, whole genome DNA extraction. Other than changing treatment if the Appellant does not have dopa-responsive dystonia, the submitted documentation did not indicate how the test result would affect the Appellant's treatment plan. The Medical Consultant testified that there is other testing available regarding Segawa syndrome. Further, whole genome analysis is very broad and only a small portion of the resulting information can be interpreted at this time. Accordingly, the Department's determination must be upheld based on the available information.

As discussed during the hearing proceedings, a new prior authorization request can be submitted at any time with additional information supporting medical necessity. Further, prior authorization could also be requested for other more specific testing. The documentation submitted with any prior authorization request should address medical necessity, including how the testing result would affect the treatment plan for the Appellant.

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 prior authorization request for blood test for developmental delays/genetics based upon the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s\
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/7/2013

***** 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.