

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:

██████████,

Docket No. 2013-43020 QHP
Case No. 15366847

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 ██████████. The Appellant appeared without representation. She had no witnesses. ██████████, Medicaid manager, represented the MHP [██████████]. He had no witnesses.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Botox injections?

FINDINGS OF FACT

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

1. At the time of hearing the Appellant is a █████-year-old, female Medicaid beneficiary. (Appellant's Ex. #1)
2. She has been covered by the MHP since ██████████. (Appellant's Ex. #1)
3. The Appellant is afflicted with gastroparesis and IBS. (Appellant's Ex. #1, Respondent's Ex. A, pp. 1 and 19)
4. On ██████████, the MHP received a request for approval of Botox 100 unit IM for the treatment of the Appellant's gastroparesis. (Respondent's Exhibit A, pp. 11-14)
5. On ██████████, the Appellant's request was denied for failure to meet ██████████ criteria for the coverage of Botox for the treatment of gastroparesis. The MHP also advised the physician's office that if important information was not provided - they should resubmit. (Respondent's Ex. A, pp. 1,7,9, 22-23)

6. The Appellant's further appeal rights were contained therein.
7. The instant request for hearing was received by the Michigan Administrative Hearing System (MAHS) for the Michigan Department of Community Health on [REDACTED]. (Appellant's Ex. #1)

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 Health Plan of Michigan 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

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- 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/EPSTD for persons under age 21

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

....

Utilization Management

(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.

....

Contract, *Supra*, at page 49.

Furthermore, the Medicaid Provider Manual (MPM) sets forth specific service requirements for MHPs to follow:

SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for individuals under age 21 (Emphasis supplied)

MPM §1.1 (Medicaid Health Plans) July 1, 2012, pages 1 – 2¹.

The Appellant testified that she is still real sick and has lost 80-pounds. She said she is eating some food and is feeling better - particularly with the recent addition of a feeding tube implanted on ██████████. She said that her doctor told her “yesterday” she was improving “...but not as fast as before.”

The MHP witness testified that when the Appellant’s requesting physician submitted information on PA he indicated that the Appellant could consume solid food. The Appellant agreed, stating that she would like to be able to eat more - so she might “regain her strength.” The MHP witness testified that member/patients seeking Botulinum therapy must meet the same criteria as one who required total parenteral nutrition (TPN). The Appellant’s physician documented that she could consume solid food. [See Respondent’s Exhibit A, p. 17]

The physician’s office was advised to send additional information for review if they believed that important information was missing from their PA request.


The Respondent witness verified that the PA failed to meet its published utilization management criteria for approval of “Botox-therapy” for the treatment of gastroparesis.² The Appellant, who acknowledged on the record that she is “...still real sick,” said she is [nevertheless] improving.

The Appellant has the burden of proving medical necessity to reverse this decision. Based on the evidence submitted by her physician and her testimony she has failed to do so.

The Respondent Health Plan, under these facts, properly denied the PA for the medication Botox.

¹ This version of the MPM is substantially similar to the edition in place at the time of appeal.

² See Respondent’s Ex. A at page 7.


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DECISION AND ORDER


The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that MHP properly denied the Appellant's request for Botox.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

ls_____

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health


Date Signed: 7/24/2013

Date Mailed: 7/24/2013

cc:



***** 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.