

**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:

██████████

Appellant

Docket No. 2013-65323 QHP

██████████

**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 was represented by ██████████ mother. ██████████ Grievance Coordinator, represented PHP Family Care, the Medicaid Health Plan ("MHP"). ██████████ RN Clinical and Quality Review Specialist, appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny the Appellant's request for coverage for an Autism Panel?

**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 ██████-year-old Medicaid beneficiary, who has been diagnosed with Autism. (Exhibit A)
2. On ██████████ the MHP received a request for coverage for an Autism Panel for the Appellant. The clinical documentation noted the Appellant has never had any lab or blood work done to rule out other serious causes of pervasive developmental disorder. (Exhibit A)
3. The ██████████, Hayes GTE Rating System for the Genomic Microarray Analysis for Intellectual Disability, Developmental Delay, Multiple Congenital Anomalies, and Autism Spectrum Disorders (Various Manufacturers) for the use of diagnostic evaluation of individuals with ASD, including autism, Asperger syndrome and pervasive developmental disorder has a Hayes Genetic Test Rating of D2. The rating of D2 is described as "**Insufficient evidence**". There is insufficient published

evidence to assess the analytical and/or clinical validity of the test for the application(s) assessed. (Exhibit I)

4. On ██████████, the MHP sent the Appellant a letter stating the request for coverage for an Autism Panel was denied because the current guidelines for genetic testing for Autism Panel state there is insufficient published evidence to assess the analytical and/or clinical validity of the test for the applications(s) assessed. (Exhibit B)
5. On ██████████, the MHP received an appeal from the Appellant's mother. (Exhibit C)
6. On ██████████, the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf. (Exhibit E)
7. The MHP completed an internal review for this denial, including a grievance hearing. (Exhibits D, F and G)
8. On ██████████, the MHP issued a letter to the Appellant indicating the determination to deny coverage for the Autism Panel was upheld by the Grievance Committee because it is considered unproven and therefore is specifically excluded. (Exhibit G)

### **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 Respondent is one of those MHPs.

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/EPSTD 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.

....

Contract, *Supra*, p. 49

As stated in the Department-MHP contract language above, a MHP, “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

**1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING**

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

*Department of Community Health,  
Medicaid Provider Manual, Medicaid Health Plans Section  
Version Date: July 1, 2013, Page 3  
(Underline added by ALJ)*

On ██████████ the MHP received a request for coverage for an Autism Panel for the Appellant. On ██████████ the MHP sent the Appellant a letter stating the request for coverage for an Autism Panel was denied because the current guidelines for genetic testing for autism panel state there is insufficient published evidence to assess the analytical and/or clinical validity of the test for the applications(s) assessed. The records state the Appellant has Autism, but has not had blood work done for possible causes of pervasive developmental disorder. The genetic test is not a proven test for this problem. PHP Family Care does not pay for unproven services. (Exhibits A and B)

The MHP explained that the Appellant’s request for coverage for an Autism Panel was reviewed utilizing the ██████████ Hayes GTE Rating System for the Genomic Microarray Analysis for Intellectual Disability, Developmental Delay, Multiple Congenital

Anomalies, and Autism Spectrum Disorders (Various Manufacturers). (Exhibit I) For the use of diagnostic evaluation of individuals with ASD, including autism, Asperger syndrome and pervasive developmental disorder, the test has a Hayes Genetic Test Rating of D2. (Exhibit 1, page 2) The rating of D2 is described as “**Insufficient evidence**. There is insufficient published evidence to assess the analytical and/or clinical validity of the test for the application(s) assessed.” (Exhibit I, page 1)

The Appellant’s mother disagrees with the denial. The Appellant’s mother testified there is nothing she can do, she has been told no many times. However, the Appellant’s mother also stated they have recently received an approval notice regarding four of the seven tests included in the Autism Panel. The Appellant’s mother wanted to confirm that approval, and proceed with those tests. (Mother Testimony)

The Clinical and Quality Review Specialist stated it is possible the criteria were met for those specific tests and she will follow up with the Appellant’s mother regarding the approved testing. (Clinical and Quality Review Specialist Testimony)

While this ALJ sympathizes with the Appellant’s circumstances, the above cited Medicaid policy states that MHPs are prohibited from covering experimental or investigational drugs, procedures or equipment. The ██████████ Hayes GTE rating of D2 for the requested test for the stated application is sufficient evidence that the requested service is considered experimental or investigational at this time. The MHP’s denial of this prior authorization request for coverage for an Autism Panel was consistent with the Medicaid policy and must be upheld.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant’s request for coverage for an Autism Panel based on the available information.

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan’s decision is AFFIRMED.

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

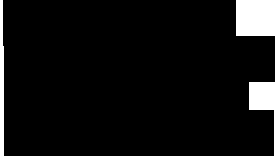
Date Signed: ██████████

Date Mailed: ██████████

**Docket No. 2013-65323 QHP**  
**Decision and Order**

CL/db

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.