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. 14-012675 MHP
Case No. [redacted]

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 on [redacted]. [redacted], Appellant's parent and guardian, appeared and testified on Appellant's behalf. [redacted], Occupational Therapist appeared as a witness.

[redacted], Manager of Medicaid Operations, represented the Medicaid Health Plan (MHP), [redacted].

ISSUE

Did the MHP properly deny the Appellant's request for a Rifton Toileting System and Components?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted]-year-old Medicaid beneficiary, born [redacted], who is diagnosed with hydranencephaly. (Exhibit A.4;Testimony)

2. On or about [redacted], the MHP received a Prior Authorization Request from Appellant's PCP on behalf of Appellant for a Rifton Toileting system with components. (Exhibit B.6-11)

3. On [redacted], the MHP advised Appellant and the supplier that the request was denied because it was determined that the system was determined to be non-standard durable medical equipment (DME) and that there are economic alternatives. (Exhibit C.13-14; Testimony)

4. On or about [redacted], Michigan Administrative Hearing System (MAHS) received a Request for Hearing on Appellant's behalf. (Exhibit A.2-3)

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 MHPs.

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/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:

(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. [Contract, *Supra,* p. 49].

The MHP offered into evidence Section 5 regarding the schedule of covered services laying out the requirement of medical necessity. (Exhibit D) In this section, the MHP also offered into evidence the durable medical equipment (DME) section in the certificate of coverage. (Exhibit D.17) In further support of its denial, the MHP offered into evidence its Medical Policy regarding DME. (See Exhibit E.19-23) That policy specifically excludes what is considered to be deluxe equipment. (Exhibit E.21)

At the hearing, Appellant requested that the MHP offer into evidence a definitions of of standard medical equipment and medical necessity. The MHP indicated that the medical review team who made the decision were not present at the hearing and no testimony could be elicited regarding the same.

The MHP did submit a number of applicable portions of Priority Health's contract and medical policy (91110-R13) (Exhibit A). However, federal and state mandates, and, more specific descriptions of durable medical equipment is found in the MDCH Medical Provider Manual which the MHP must follow as part of its contractual obligations under federal and state law. The Medicaid Provider Manual Version October 1, 2014, on the Medical Supplier Chapter states that medical devices can only be covered if they are the most cost-effective available. Page 4. Furthermore, DME is defined in Sec 1.8 as that which is medically necessary and meet the medical and/or functional needs of the beneficiary. Page 13.

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 Medicaid Provider Manual, Medical Supplier Chapter, §2.7 Children's Products and §2.8, Commodes, July 1, 2013, p 27 states:

> Children's products that may be considered for coverage include, but are not limited to, equipment that is used in the home or vehicle by children under age 21 for the purposes of positioning, safety during activities of daily living, or assisted mobility. Examples of these items include: bath supports, specialized car seats, corner chairs, dynamic standers, feeder seats, gait trainers, pediatric walkers, positioning commodes, side lyers, standers, and toileting supports.

The MHP's witness testified that the requested toileting system was denied as it was not considered standard medical equipment but rather deluxe, and was not the most economically feasible alternative. The MHP witness further testified that the MHP has yet to complete an assessment of economic alternatives. In fact, the MHP's representative indicated that if the individual with the MHP determines, at some future point in time, that there are no economic alternatives, then the request here would be approved.

Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested toileting system. As indicated above, the MHP must ensure that the requested device is the most economical alternative to meet Appellant's needs. While this ALJ can understand Appellant's frustration with the process, the review herein is whether the MHP properly denied on the basis of the system being deluxe at the time the MHP processed the request, based on the information available at that time. As Appellant did not show that the MHP erred, this ALJ must uphold the denial. However, as noted by the MHP, the initial request can be, and will be reconsidered if the MHP cannot show any economic alternatives.

As the case stands, this ALJ must uphold the denial.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for a Rifton toileting system was proper based on the information available .

IT IS THEREFORE ORDERED that:

The MHP's decision is **AFFIRMED**.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

RJM[redacted]

Date Signed: [redacted]

Date Mailed: [redacted]

cc: [redacted]

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.