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. 14-018129 MHP

[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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared on his own behalf. [redacted], Senior Associate General Counsel appeared on behalf of the Department's MHP U[redacted] [redacted], Chief Medical Officer appeared as a witness for the MPH.

ISSUE

Did the MHP properly deny the Appellant's request for a facility based sleep study?

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 (DOB [redacted]) Medicaid beneficiary. (Exhibit A, pp. 3, 32 and testimony).

2. On [redacted], the MHP received a phone call regarding a Prior Authorization (PA) Request from [redacted]., on behalf of the Appellant for a facility based sleep study. On [redacted] the MHP sent the Appellant's doctor a request for clinical information with BMI or height and weight, and diagnostic test results, Pulmonary Function Test results for COPD. (Exhibit A, p. 53 and testimony).

3. On N[redacted]r[redacted], the MHP received clinical information on behalf of the Appellant in connection with his request for a laboratory sleep study. (Exhibit A, pp. 39-51 and testimony).

4. On [redacted] QHP Physician Advisor, [redacted], denied the facility based sleep study for not meeting [redacted] Guidelines for Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders, CS098.B. (Exhibit A, pp. 3, 4-29).

5. [redacted]e Guidelines for Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders, CS098.B, states in pertinent part:

> **Attended full-channel nocturnal polysomnography (NPSG)/laboratory sleep test (LST), performed in a healthcare facility is proven and medically necessary in patients *not previously diagnosed* with OSA with <u>one (1) or more</u> of the following indications:**
>
> A. <u>one (1) or more</u> of the following co-morbid conditions that would degrade the accuracy of portable monitoring with a home sleep test (HST):
>
> 1. significant <u>chronic pulmonary disease</u> as defined by a force expiratory volume (FEV 1% pred) of ≤ 60 (Pelligrino, 2005).
>
> 2. Neuromuscular disease/neurodegenerative disorder [examples include but are not limited to, Parkinson's disease, myotonic dystrophy, amyotrophic lateral sclerosis, multiple sclerosis with associated pulmonary disease]
>
> 3. Significant cardiac disease [examples include but are not limited to, congestive heart failure (NYHA class III or IV), uncontrolled significant cardiac arrhythmia, pulmonary hypertension, history of prior stroke]
>
> 4. Body mass index (BMI) ≥50 (<u>DeMaria 2007</u>, <u>Blackstone 2009</u>)
>
> 5. <u>Obesity Hypoventilation Syndrome</u> (OHS); **OR**

B. one (1) or more of the following complex sleep disorders:

1. periodic limb movement disorder

2. parasomnia with disruptive, violent or potentially injurious sleep behavior suspicious of rapid eye movement (REM) (RBD) disorder

3. narcolepsy once other causes of excessive sleepiness have been ruled out

4. history of central sleep apnea: (Exhibit A, pp. 5-6).

6. On [redacted], denial letters were sent to the Appellant and the Appellant's doctor. The reason for the denial was that denial was that the Appellant did not have a BMI of [redacted] or greater, and did not have a health condition that would require him to be monitored at a facility during the sleep study. There was no report that the Appellant had severe lung disease. (Exhibit A, p. 3 and testimony).

7. On [redacted] the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 8).

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In

general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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, 1/23/2013, pp. 22-23].

* * *

AA. Utilization Management

(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. 55].

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior authorization request under UnitedHealthcare's internal policies for Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders, CS098.B. (Exhibit A, pp. 4-29).

Respondent's witness [redacted] established that on [redacted] the MHP received a phone call regarding a PA request from [redacted]., on behalf of the Appellant for a facility based sleep study. On [redacted] the MHP sent the Appellant's doctor a request for clinical information with BMI or height and weight, and diagnostic test results, Pulmonary Function Test results for COPD. On [redacted] the MHP received clinical information on behalf of the Appellant in connection with his request for a facility based sleep study.

[redacted] stated on [redacted], MHP Physician Advisor, [redacted] denied the facility based sleep study for not meeting UnitedHealthcare Guidelines for Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders, CS098.B. On [redacted], denial letters were sent to the Appellant and the Appellant's doctor. [redacted] stated the reason for the denial was that the Appellant did not have a BMI of [redacted] or greater, and did not have a health condition that would

require him to be monitored at a facility during the sleep study. There was no report that the Appellant had severe lung disease. (See Exhibit A, p. 3).

[redacted] stated in connection with the Appellant's appeal he reviewed the PA request, the medical notes, and [redacted] guidelines. [redacted] stated a facility based sleep study was denied, but a home based sleep study was approved. [redacted] stated he upheld the denial of a facility based study for not meeting the MHP's internal policy for this test. (See Exhibit A, pp. 5-6). He stated the crucial factor resulting in the denial was the results of the Pulmonary Function Test which indicated the Appellant's pulmonary function was within normal limits. (Exhibit A, p. 2 and testimony).

The Appellant testified that he believes he needs a facility based test because he moves around a lot and the connections might come loose resulting in incomplete test results. He said he was not comfortable with doing the test in his home, or having others come into his home. Appellant said that his sister or his friends have told him they have to wake him up because he stops breathing. He said he thought a facility based test would be more accurate.

The Appellant failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied his request for a facility based sleep study in favor of a home based test.

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 facility based sleep study and the authorization instead of a home based test was proper.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Acting Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]
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WDB/db

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.