

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. 2014-17505 QHP
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on his own behalf. Appellant's mother, Soson Mohede appeared on behalf of Appellant.

██████████, subcontracting on behalf of the State of Michigan, provided an ██████████ language interpreter.

Respondent-PHP Family Care, (MHP), subcontracting on behalf of the Michigan Department of Community Health had two witnesses: ██████████, Grievance Coordinator, and ██████████, Clinical Control Specialist

ISSUE

Did the MHP properly deny Appellant's request for physical therapy (PT) services?

FINDINGS OF FACT

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

1. Appellant is a ██████ year old male with multiple sclerosis who is using a wheel chair.
2. Appellant was previously approved PT consisting of 12 sessions.
3. On ██████████ the MHP received a request for 6 additional sessions.
4. On ██████████ the MHP testified that it denied Appellant's request for additional PT stating in part: "You have no complaints of pain...you have met most of the goals set for you and you have improved strength and

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range of motion in your arms...and you have not increased your ability to be active or more-self-sufficient..." (Exhibit A.3) At hearing the MHP indicated that the date of denial was ██████████.

5. ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing.

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.

In 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 is in one of those Medicaid Health Plans.

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

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- 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

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- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21

*Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.*

- (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

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The Applicable Medicaid Provider Manual Chapter and Sections is found in Exhibit A.39-41)

In addition, the MHP submitted portions of its MHP Certificate of Coverage Sections regarding the definition of medical necessity. (Exhibit A.43) Medical Necessity is also defined in the MPM in the Mental Health/Substance Abuse Chapter under Section 1.7 Definition of Terms, and, further defined under Section 2.5.A and 2.5.B-Medical Necessity Criteria and Determination Criteria. Also see the MPM Section 2.5.D wherein it states:

...A PIHP may not deny services based solely on present limits of the cost. MPM Mental Health/Substance Abuse, Section 2.5.D., Version April 1.2014

In this case, the MHP's evidence indicates that Appellant's continued PT will not meet the rehabilitative criteria. While a different health plan, one not established for welfare clients, may have less strict requirements, which is not the case here. This plan employs medical necessity criteria which, while not completely driven by financial cost savings purpose, are in part driven by these considerations to the extent that continuing services must be shown to be rehabilitative. Thus, the denial must be upheld as continued services are not a covered service under these facts.

It is unclear from the record whether Appellant may have eligibility if requested by his physician(s). In this case, the request was based on a continuing request by the physical therapist.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying that request. Here, Appellant has failed to meet that burden.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

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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.