

**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. 2014-20597 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.

██████████, paralegal, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████, MD, Medical Director testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request to have his sleep study done at a health care facility?

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 beneficiary of the Medicaid program, administered by the State of Michigan.
2. Appellant has a BMI of about 27. Appellant has been diagnosed with sleep disruption. (Exhibit B.1)
3. On ██████████ Appellant's physician filed a prior authorization request for a sleep study. Appellant requested that the study be done in a health care facility; Appellant's physician agreed that it could be done in Appellant's home. (Testimony)
4. On ██████████ the MHP sent Appellant written notice that the request for a sleep study was approved; Appellant's request to have the study done in a

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health care facility was denied on the grounds that the information provided does not show any health condition that would require Appellant to be monitored in a facility during the sleep study. (Exhibit A.1)

5. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on behalf of Appellant disputing the portion of the denial to have the study done in a health care facility.

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. With respect to such MHPs, their contract with the Michigan Department of Community Health ("MDCH" or "Department") provides:

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

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- 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

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- (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

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

The applicable contract also provides:

- (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.

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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 MHP Medical Policy is found in Exhibit C, submitted at the administrative hearing. That document is in conformance with the requirements in the Michigan Medicaid Provider Manual (MPM). Specifically, the chapter applicable to the case herein is titled: “Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders,” Effective [REDACTED].

In this case, the MHP has determined that the most cost effective/medically necessary study for Appellant is by use of machine in his home. Appellant contends that he is nervous about the unit being damaged and/or not being properly returned which could potentially incur a cost for him.

Evidence submitted by the MHP indicates that it contacted Appellant’s Primary care physician who agreed that a home sleep study can be done in Appellant’s home. (Exhibit A.2) There are no medical indications that would require Appellant to have the study done at a health care facility. Appellant’s concerns are not recognized at law or policy as a basis upon which Appellant can prevail. Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying that request.

After a careful review of the credible and substantial evidence, this ALJ finds that Appellant has failed to meet that burden. The MHP’s decision is upheld.


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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 to have his sleep study done at a health care facility.

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


Date Signed: March 31, 2014

Date Mailed: April 1, 2014

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 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.