

**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.** 2014-22557 QHP  
**Case No.** ██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████, Appellant's Representative appeared and testified on the Appellant's behalf. ██████████, Manager of Medicaid Services, represented ██████████, the Medicaid Health Plan (MHP).

**ISSUE**

Did the MHP properly deny the Appellant's request to cover genetic testing?

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in the Respondent MHP. (Respondent's Exhibit A, p. 2; Testimony).
2. On ██████████, the MHP received a Medical Prior Authorization Form from the Appellant's doctor for a "Dual Genome NGS Panel by Massively Parallel Sequencing". (Exhibit A, pp. 10-20)
3. On ██████████, the MHP sent the Appellant written notice that the "Dual Genome NGS Panel by Massively Parallel Sequencing" request was being denied. (Exhibit A, pp. 22, 23)
4. Specifically, the denial stated:

Based on review of the information provided  
the following determination has been made:

Information reviewed shows you do not meet #4b. . . as the test results will not lead to a marked change in the intensity of surveillance frequency and/or intensity of treatment for that disease. (Exhibit A, p. 23)

5. On ██████████, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant with respect to the denial of her “Dual Genome NGS Panel by Massively Parallel Sequencing” request. (Exhibit A, pp. 5-8)

### **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 Michigan Department of Community Health 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 Medicaid Health Plans.

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 coverage's 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:

Article 1.020 Scope of [Services],  
at §1.022 E (1) contract, 2013, pp. 22, 23.

The Michigan Medicaid Provider Manual (MPM) states:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements.

MPM, MHP, §1, p. 1. July 1, 2013.

Here the MHP developed utilization guidelines for genetic testing and those guidelines include the following criteria.

- I. Policy/Criteria
  - a. Coverage for genetic counseling, testing and/or screening is provided to [REDACTED] members when ALL of the following apply:
    - i. Appropriate genetic counseling occurs before and after testing.

- ii. Documented informed consent occurs before testing.
- iii. There is documented reasonable expectation based on family history, pedigree analysis, risk factors, and/or symptomatology that a genetically inherited or acquired condition exists and the member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic) or comes from the appropriate disease-specific population. A three generation pedigree should accompany the request for testing.
- iv. **Knowledge of the presence or absence of condition would directly affect medical care of the member.**
  - 1. The disease is treatable and/or preventable and
  - 2. **The test results will lead to a marked change in the intensity of surveillance frequency and/or intensity of treatment for that disease.**
- v. The testing is FDA/CLIA approved.
- vi. Testing is ordered by the appropriate provider.

[REDACTED] *Medical Policy No. 91540-R9*  
*October 18, 2013*  
*Genetics: Counseling, Testing, Screening, p. 1.*

The DCH-MHP contract provisions also allow for prior approval procedures for utilization management purposes.

- (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 . . .

Contract, *Supra*, p. 55

Pursuant to the above guidelines, the MHP denied the genetic testing request because the review team determined that the testing would not lead to a marked change in the intensity of surveillance frequency and/or intensity of treatment for that disease.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying the request. In this case, given the above policy and the evidence found in the record, Appellant has failed to meet that burden of proof and the MHP's decision must be affirmed.

Although the genetic testing request hinted at possible changes to the treatment of conditions, those conditions do not pertain to the underlying condition of a mitochondrial disorder. In fact, the requests indicate the goal is to "prevent further issues, not cure a mitochondrial disorder." (Exhibit A, p. 16) This does not satisfy [REDACTED] Medical Policy. The test in question is to "test for mutations in the mitochondrial and nuclear genome related to mitochondrial disorder." (Exhibit A, p. 11) The policy in question requires the test results to lead to a change in the intensity of surveillance frequency and/or intensity of treatment for the disease (mitochondrial disorder).

Accordingly, the MHP's decision must be affirmed.

**DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED** that:

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

\s\ \_\_\_\_\_  
Corey A. Arendt  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

[REDACTED]  
Date Signed: February 28, 2014

Date Mailed: February 28, 2014

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 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.