

**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. 2014-35119 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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Inquiry Dispute Appeals Resolution Coordinator, represented ██████████ Healthcare of Michigan, the Medicaid Health Plan ("MHP"). Dr. ██████████, Medical Director, appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny Appellant's request for a breast pump?

**FINDINGS OF FACT**

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

1. Appellant is a ██████-year-old Medicaid beneficiary, born ██████████. (Exhibit A, p 5; Testimony)
2. On or about ██████████, the MHP received a Prior Authorization Request from Dr. ██████████, MD on behalf of the Appellant for a breast pump. The diagnosis listed in the prior authorization request supporting the request for a breast pump was 783.3 feeding difficulties. (Exhibit A, pp 4-6; Testimony)
3. On ██████████, the MHP advised Appellant and the supplier that the request for a breast pump was denied because the information supplied did not show that Appellant's child has a cleft lip or cleft palate, oral motor dysfunction, or that there is a physical separation between the mother and infant, as required under Section 2.5 of the Medicaid Provider Manual (MPM). (Exhibit A, pp 7-8; Testimony)

4. Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS) on ██████████. (Exhibit 1)

### **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/EPSTD 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].

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, §2.5 Breast Pumps, April 1, 2014, p 25 states:

**2.5 BREAST PUMP**

**Definition**

A hospital grade electric breast pump is heavy duty, piston-operated, and is capable of being used frequently on a daily basis.

**Standards of Coverage**

A hospital grade electric breast pump may only be covered for a beneficiary with a Neonatal Intensive Care Unit (NICU) infant, up to three months of age, when one of the following applies:

- The infant has a severe feeding problem secondary to cleft lip and/or palate.

- The infant has a severe feeding problem due to oral motor dysfunction, secondary to prematurity.
- The infant is hospitalized resulting in a physical separation of the mother and infant.

For continued coverage beyond the initial three months, additional documentation must be provided.

### **Documentation**

Documentation must be less than 30 days old and include:

- Diagnosis/medical condition of the infant relating to the need for a breast pump.
- Infant's age (gestational age, if premature).
- Mother's discharge date.
- Anticipated duration of need.

### **PA Requirements**

PA is not required when the Standards of Coverage are met.

PA is required for coverage beyond three months.

### **Payment Rules**

A breast pump is considered a **rental only** item and is inclusive of the following:

- All related accessories necessary to use the equipment (To obtain additional reimbursement for the initial breast pump kit, report the "KH" modifier with HCPCS code E0604 for the first month of rental only).
- Education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs or replacements to make the unit functional.

The rental pump may be billed using the infant's Medicaid ID number if the need for the hospital grade pump meets the

standards of coverage and the mother loses Medicaid eligibility.

The MHP's medical director testified that the requested breast pump was not a covered item under *the Medicaid Provider Manual, Medical Supplier, §2.5. Breast Pump*. The MHP's medical director stated that the information submitted did not show that one of the conditions required under Section 2.5 of the MPM for a breast pump to be covered had been met. While Appellant's child does have some feeding difficulties, the child does not have a cleft lip or cleft palate, oral motor dysfunction, and there has been no physical separation between the mother and infant. The MHP's medical director concluded that the denial of the prior authorization request in this case should be upheld.

Appellant testified that her baby was in the neonatal unit for one week and that she was separated from him for a couple of days, but was able to then be in the neonatal unit with him. Appellant testified three different medical professionals have written prescriptions for a breast-pump because the baby had difficulty latching on to her breast to feed.

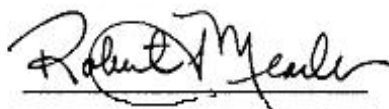
Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested breast pump. As indicated above, breast pumps are covered only if the child has a cleft lip or a cleft palate, oral motor dysfunction, or there has been a hospitalization causing a physical separation of the mother and infant. None of these factors are present for in the instant matter. As such, the denial was proper.

### **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 breast pump was proper.

**IT IS THEREFORE ORDERED** that:

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



Robert J. Meade  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

[REDACTED]  
Docket No. 2014-35119 QHP  
Decision and Order

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.