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:

[redacted]

Docket No. 14-017631-MHP
Case No. [redacted]

Appellant.
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted], Manager, Medicaid Operations, appeared on behalf of the Medicaid Health Plan, [redacted] ([redacted] or MHP).

ISSUE

Did [redacted] properly deny Appellant's request for a Prothrombin Time International Normalized Ratio (PT/INR) home monitoring system?

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 [redacted] year old Medicaid beneficiary, born [redacted]. Appellant is diagnosed with Factor V Leiden Mutation, which causes her to experience blood clots at any time. Appellant is a double amputee above the knee because of this condition. (Exhibit A, pp 1, 5; Testimony).

2. On [redacted], [redacted] received a prior authorization request from Appellant's physician for a PT/INR home monitoring system. (Exhibit B, Testimony).

3. On [redacted], [redacted] issued a denial of Appellant's prior authorization request for a PT/INR home monitoring system because the monitoring system was excluded from coverage. (Exhibit C; Testimony)

4. On [redacted], [redacted] received another prior authorization request from Appellant's medical equipment supplier for a PT/INR home

monitoring system, as well as home monitor training. (Exhibit D; Testimony)

5. On [redacted], [redacted] issued a denial of Appellant's prior authorization request for a PT/INR home monitoring system and training because the monitoring system was excluded from coverage. (Exhibit E; Testimony).

6. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on behalf of Appellant. (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.

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 and, regarding such plans, the Michigan Medicaid Provider Manual states:

> **SECTION 1 – GENERAL INFORMATION**
>
> 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. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days

- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral-maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services (Refer to the Dental chapter of this manual for additional information.)

- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)

- Home and Community Based Waiver program services

- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)

- Maternal Infant Health Program (MIHP)

- Mental health services outside the MHP's contractual responsibility

- Outpatient partial hospitalization psychiatric care

- Personal care or home help services

- Private Duty Nursing services

- Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)

- Services provided by a school district and billed through the Intermediate School District

- Substance abuse services through accredited providers, including:

- Screening and assessment;

- Detoxification;

- Intensive outpatient counseling and other outpatient services; and

- Methadone treatment

- Transportation for services not covered by the MHP.

1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

Medicaid Provider Manual
Medicaid Health Plans Chapter
October 1, 2014, pp 1-3

With regard to PT/INR home monitoring systems, [redacted]'s Medical Policy, No. 9157-R3 states:

> Coverage for Medicaid and MIChild members: Home Prothrombin Time/INR monitors are not a covered benefit.
>
> (Exhibit F, p 35)

Furthermore, [redacted]'s Medicaid Certificate of Coverage, Exclusions of Coverage, provides:

> Durable Medical Equipment (DME) and Devices – Equipment and devices solely for the convenience of you or your caretaker are excluded.
>
> (Exhibit G)

Pursuant to the above policy, [redacted] denied Appellant's request for a PT/INR home monitoring system because such monitoring systems are specifically excluded from coverage and because such a monitoring system would amount to a convenience device for Appellant in this case.

Appellant bears the burden of proving by a preponderance of the evidence that [redacted] erred in denying her request based upon the information that was submitted to it in connection with the prior authorization request for a PT/INR home monitoring system. Here, Appellant has failed to meet that burden of proof.

Appellant testified that her medical condition means that her blood will clot for no reason. Appellant indicated that she is now a double amputee because of this condition and will be on blood thinners for the rest of her life. Appellant testified that she required frequent blood monitoring because of the blood thinners and that it is very difficult for

her to get to the lab for such monitoring in the winter months. Appellant also noted, however, that she has now made arrangements for someone to come to her house to conduct the blood monitoring and that this has been happening for the past few weeks.

The MHP, and likewise the undersigned administrative law judge are bound by the policies set forth in the Medicaid Provider Manual. The preponderance of the evidence in this case shows that while the PT/INR home monitoring system requested by Appellant would certainly make her life easier, the device is simply excluded from coverage under Medicaid. Furthermore, even if the device was not specifically excluded from coverage, it might be denied as a convenience item. Finally, it appears that Appellant's issue with having difficulty getting to the lab for blood monitoring in the winter months is moot given that Appellant has now made arrangements for someone to come to her home to conduct the monitoring. Accordingly, Appellant has failed to demonstrate that the MHP erred in denying a PT/INR home monitoring system.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly denied Appellant's request for a PT/INR home monitoring system.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

RJM/[redacted]

Date Signed: [redacted]

Date Mailed: [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.