STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-018596 MHP
Case No.

,

Appellant
_____________________/

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 telephone hearing was held on . Appellant was represented at the hearing by her mother, . , Paralegal; and Dr. , Medical Director appeared and testified on behalf of (MHP or or Respondent).

Respondent's Exhibit A pages 1-29 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's prior authorization request for an insulin 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 minor child DOB .

2. ("MHP") is contracted with the state of Michigan to arrange for the delivery of health services to Medicaid recipients.

3. At all times relevant to this case, Appellant was enrolled in the MHP.

4. On , received a Prior Authorization request from Appellant's physician, requesting the purchase of an insulin pump.

5. On , sent Appellant Notice of denial stating that state and health plan rules for the device were not met;

Appellant's blood sugar was not out of control and her AC1 was <6.3%. (Respondent's Exhibit A page 5)

6. On [redacted], Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS) to contest the negative action.

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/EPSDT 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."

Under the (MDHHS)-MHP contract provisions, an MHP may devise their own criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services.

Medicaid Provider Manual, Medical Supplier, Section 2.14 External Infusion (Insulin) Pump and Related Supplies (October 1, 2015) states in pertinent part:

Insulin pumps deliver a constant and continuous infusion of insulin, driven by mechanical force, into the subcutaneous space via a needle or soft cannula.

Standards of Coverage

Insulin pumps are covered when other methods to control blood glucose levels have been ineffective and one of the following applies:

- Blood glucose levels demonstrate poor glycemic control despite monitoring at least four times per day and multiple daily insulin injections with a persistently elevated glycosylated hemoglobin level greater than seven percent.

- There is a history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reaction, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements.
- There is evidence of the "dawn" phenomenon where fasting blood glucose level often exceeds 200 mg/dl.

Documentation must be less than 90 days old and include:

- Diagnosis/medical condition pertaining to the need for the pump.
- Lab values of blood glucose levels.
- Medical history documenting the need for the pump.
- Any medical complications experienced by the beneficiary related to the need for blood glucose monitoring.

CSHCS requires ***a prescription from an appropriate pediatric subspecialist.***

PA is not required if the Standards of Coverage are met, and:

The beneficiary is over the age of 16 and has one of the diagnoses indicated below:

- Diabetes Mellitus without Complication
- Diabetes with Ketoacidosis
- Diabetes with Hyperosmolarity
- Diabetes with Other Coma
- Diabetes with Renal Manifestations
- Diabetes with Ophthalmic Manifestations
- Diabetes with Neurological Manifestations
- Diabetes with Peripheral Circulatory Disorders
- Diabetes with Other Specified Manifestations
- Diabetes with Unspecified Complication
- Diabetes Mellitus Complicating Pregnancy

The beneficiary is under the age of 16, has one of the diagnoses above, and the pump is ordered by a pediatric endocrinologist.

Appellant's respresentative testified on the record that Appellant's blood sugars are not controlled and she would like to submit additional information and a new request for the insulin pump.

The MHP Medical Director testified on the record that since diagnosis Appellant has had excellent improved and good control over her diabetes over a three month period of time. Thus, Appellant's diabetes is controlled based upon submitted medical documentation. She is able to self-monitor her blood sugars. Appellant does not have persistently high blood glucose and only one episode of dawn phenomena. Her HbA1C

level is 7.0% or 1% over upper range of normal. (Respondent's Exhibit A page 10)

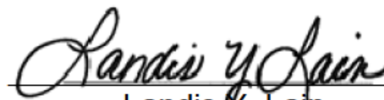
In the instant case, Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested insulin pump. The (MHP), does not have discretion to approve Appellant's request for items when insufficient evidence in support of medical necessity has been provided. Appellant's physician may resubmit a Prior Authorization request for an insulin pump with the appropriate documentation and the MHP will be able to consider the request. The decision to deny the request for prior authorization for an insulin pump must be upheld under the circumstances.

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 an insulin pump was proper under the circumstances.

IT IS THEREFORE ORDERED that:

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



Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

LYL/

cc:

Date Signed: December 22, 2015

Date Mailed: December 23, 2015

*** 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.