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. 15-019434 MHP
[REDACTED], Case No. [REDACTED]

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 [REDACTED]. Appellant appeared and testified on her own behalf. [REDACTED], Appeals Coordinator for [REDACTED] Health Plan (MHP or [REDACTED] or Respondent) appeared and testified on behalf of McLaren Health Plan.

Respondent's Exhibit A pages 1-16 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's Prior Authorization request for joint replacement surgery in the shoulder?

FINDINGS OF FACT

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

1. [REDACTED] Health Plan ("MHP") is contracted with the State of Michigan to arrange for the delivery of health services to Medicaid recipients.

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

3. On [REDACTED], the MHP received a Prior Authorization request from Appellant's physician, requesting approval for Septoplasty.

4. On [REDACTED], the MHP sent Appellant a Notice of denial stating: the provided documentation does not show that Appellant has been treated for repeated sinus infections or that she has difficulty breathing. Per 4D Pharmacy Management, Appellant started on Flonase on [REDACTED]. This does not show an eight week trial of

conservative management, such as antihistamines or nasal steroids, or a three month or longer trial of immunotherapy have failed.(Respondent's Exhibit A page 15)

5. 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."

The MHP used the Apollo Managed Care criteria (page 2 of 7) which indicates that one or more of the following criteria will be required for coverage/payment authorization:

Nasal airway obstruction that is continuous and secondary to septal deformity due to trauma, congenital deformity or another condition nonresponsive to an eight week trial of conservative treatment and related to

1. Recurrent nasal and /or sinus infection due to nasal obstruction or difficulty breathing through the nose with a 50% air flow reduction each naris of 75% air flow reduction one nares with contralateral 25% air flow reduction or a 90 to 100% air flow either nares or
2. Recurrent epistaxis related to deformity or mouth breathing due to constant obstruction or
3. Recurrent headache or

4. Not using a topical decongestant chronically or
5. Asymptomatic septal deformity that limits access to other intranasal areas or
6. Septoplasty associated with cleft palate or
7. Associated with nasal polypectomy or associated with sinus endoscopy or
8. Atypical facial pain or
9. Nasal septal perforation.

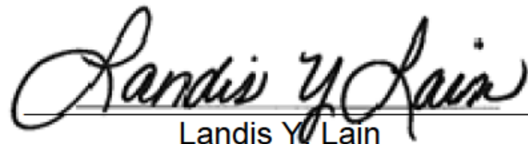
In the instant case, records from indicate that the patient presents for mouth pain for approximately 10 days. She underwent CT of the sinuses on which showed mild deviation of the septum to the right. Exam shows an "S" shaped bony septum with over 70% obstruction and deviation to the right. Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested medical procedure. The Medicaid Health Plan (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 surgery with the appropriate documentation and the MHP will be able to consider the request. The decision to deny the request for authorization 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 septoplasty 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: January 8, 2016

Date Mailed: January 8, 2016

***** 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.