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:

[redacted],

Docket No. 15-022300 MHP
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 is a minor child. Appellant's father, [redacted] and [redacted], Autism Benefit Case Manager [redacted] County appeared and testified on Appellant's behalf. [redacted], Paralegal and Dr. [redacted], Medical Director appeared and testified on behalf of [redacted] (MHP or Respondent).

Respondent's Exhibit A pages 1-26 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's request for a specialized car seat and buckles?

FINDINGS OF FACT

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

1. [redacted] ("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. Appellant is diagnosed with: Autistic Spectrum disorder, hyperactivity, expressive/receptive language disorder and poor impulse control.

4. On [redacted], United Healthcare Community Plan received a prior authorization request for a car seat with buckles for Appellant.

5. On [redacted], the MHP sent Appellant notice that the request was

denied stating: Your doctor asked for a car seat or you. Your health plan's guidelines show that this is needed or medically necessary if you cannot sit alone. It is needed if you cannot stand. It is needed if you need muscle support. We reviewed your doctor's notes. They did not contain the required information. Therefore, the doctor's request is not approved. It is not medically necessary. (Respondent's Exhibit 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 1.5 MEDICAL NECESSITY states:**

Medical devices are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter. The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature

and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician, nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, NP or PA. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDHHS standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

> The service/device meets applicable federal and state laws, rules, regulations, and MDHHS promulgated policies.
>
> It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.

Medicaid Provider Manual, Medical Supplier, Section 2.7 Children's Products, page 32 states:

> Children's Products that may be considered for coverage include, but are not limited to, equipment that is used in the home or vehicle by children under age 21 for the purposes of positioning, safety during activities of daily living, or assisted mobility.
>
> Examples of these items include: bath supports, specialized car seats, corner chairs, dynamic standers, feeder seats, gait trainers, pediatric walkers, positioning commodes, side lyers, standers, and toileting supports.

Standards of Coverage

> Children's products are covered if one or more of the following applies:
> Beneficiary is unable to independently maintain a seated position.
> Beneficiary cannot stand and/or ambulate without the aid of an assistive device.
> Beneficiary has physical anomalies that require support to allow a functional position or prevent further disability.

Documentation

Documentation must be less than 180 days old and include **all** of the following:
- Diagnosis appropriate for the equipment requested.
- Any adaptive or assistive devices currently used in the home.
- Reason economic alternatives cannot be used, if applicable.
- Statement of functional need from an appropriate pediatric subspecialist, occupational or physical therapist.

PA Requirements PA is required for all requests.

Payment Rules All children's products are considered **purchase only** items**.**

Appellant's witness testified that Appellant cannot respond or obey when his parents make requests of him due to his autism. His father has purchased a buckle guard for the car seat and Appellant is able to get out of it. Because he cannot maintain a seated position in the car Appellant is limited in his access to community inclusion and community integration. The school deems the device he uses for the bus to be medically necessary and will not transport him without the device which keeps Appellant in his seat.

According to Appellant's father, Appellant has the capability to get himself out of his car seat and walk around the car. Appellant's father has received a civil citation because Appellant was not properly restrained in the car.

Respondent's witness testified that Medicaid policy does not cover devices which are used strictly for restraint. Appellant's physician has not provided evidence of medical necessity for the specialized car seat with buckles. Appellant does not have the inability to sit. Respondent's witness suggested that Appellant's father consider a device similar to the one used by the school for transportation of Appellant.

Appellant has failed to satisfy the burden of proving by a preponderance of the evidence that the MHP improperly denied the requested childcare seat. There is no documentation contained in the evidence which indicates that Appellant has a medical condition which does not allow him to sit or stand. The denial is based upon Medicaid benefit exclusion. The Medicaid Health Plan (MHP) does not have discretion to make a decision in contravention of Medicaid policy.

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.

Items not covered by Medicaid include items used solely for the purpose of restraining

the beneficiary for behavioral or other reasons. Medicaid Provider Manual, Section 1.1

This Administrative Law Judge has limited jurisdiction over Medicaid fair hearings pursuant to a written directive signed by the Department of Health and Human Services (formerly Department of Community Health) Director James K. Haverman, on February 22, 2013. The written directive states:

> Administrative Law Judges have no authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations or overrule or make exceptions to the department policy set out in the program manuals.

This Administrative Law Judge has no equity powers to approve Appellant's request for items which are not covered Medicaid benefits. 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 the specialized car seat 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/[redacted]

Date Mailed: February 19, 2016

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 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.