**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**
P.O. Box 30763, Lansing, MI 48909
Phone: (877)-833-0870; Fax: (517) 373-4147

**IN THE MATTER OF:**

[redacted]

**Docket No.** 15-011895 PA

[redacted] [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's Grandmother, appeared and testified on Appellant's behalf. [redacted], Appeals Review Officer, represented the Respondent, Department of Community Health (DCH or Department). [redacted] Medical Consultant, appeared as a witness for the Department.

## ISSUE

Did the Department properly deny the Appellant's prior authorization request for a Psych-Markers Test?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is an [redacted] year old Medicaid beneficiary, born [redacted], who suffers from bipolar disorder, post traumatic stress disorder and borderline personality disorder. (Exhibit A, pp 10; Testimony)

2. On [redacted], the InterAct of Michigan submitted a prior authorization request on behalf of the Appellant for a Psych-Markers Test. (Exhibit A, pp 10-13; Testimony)

3. On [redacted] the Department sent the Appellant a notice indicating the prior authorization request was denied. The notice indicated the procedures were denied due to the form of the testing being considered experimental and investigational because the clinical value of the type of

genetic testing has not been established or vetted. (Exhibit A, pp 5-8; Testimony)

4. On [redacted], the Michigan Administrative Hearings System (MAHS) received from the Appellant a request for hearing. (Exhibit A, p 4)

## 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.

The Medicaid Provider Manual provides, in pertinent part, as follows:

### 8.3 Noncovered Services

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- **Experimental/investigational drugs, biological agents, procedures, devices or equipment**
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services subject to MDCH verification of medical necessity and the provider's usual and customary charge.

*Medicaid Provider Manual*
*General Information for Providers Section*
*July 1, 2015, p 18.*

### 5.5 Genetic and Molecular Testing

The following standards of coverage and prior authorization and documentation requirements apply to beneficiaries served by Fee-for-Service Medicaid. For beneficiaries enrolled in a Medicaid Health Plan, the provider must check with the beneficiary's plan for coverage and prior authorization requirements.

### 5.5.A. Standards of Coverage

Whenever possible, Michigan Medicaid follows Medicare guidelines. Medicare does not
cover a genetic test for a clinically affected individual for purposes of medical research,
family planning, disease risk assessment of other family members or when the treatment and surveillance of the beneficiary will not be affected, or in any other circumstance that
does not directly affect the diagnosis or treatment of the beneficiary.

Genetic testing **is** considered a covered benefit when it is medically necessary to establish a molecular diagnosis and treatment of a genetic disease and all of the following are met:

- The testing must be ordered by a physician (MD or DO) who is an enrolled provider.
- The beneficiary has documented clinical features symptomatic of a condition or disease, or is at risk of inheriting the disease based upon personal history, family history, documentation of a genetic mutation and/or ethnic background.
- Following history, physical examination, pedigree analysis, and completion of
- conventional diagnostic testing, a definitive diagnosis remains uncertain and a genetic diagnosis is suspected.
- **The test results will be used to significantly alter the management or treatment of the disease.**
- If applicable, the testing method is an FDA-approved method for the identification of a specific genetically-linked inheritable disease as evidenced by the following measures:
    - The genotypes to be detected by a genetic test must be shown, by scientifically valid methods, to be associated with the occurrence of the disease;
    - The analytical and clinical validity of the test must be established;
    - The observations must be independently replicated and subject to peer review; and
    - The clinical testing laboratory must be an enrolled provider who is properly certified by CLIA.

> Testing is allowed once during the beneficiary's lifetime per disease for diagnostic purposes. If medically necessary, and on a case-by-case basis, prior authorization may be requested to allow for exceptions to this restriction.
>
> Providers must follow state law (Public Act 368 of 1978, Section 333.17020 Genetic test; informed consent) regarding informed consent for predictive genetic testing. This includes any statutory requirements for pre- or post-testing genetic counseling. There must be made available, upon request, documentation of pre-testing informed consent provided before testing. This documentation must include the limitations of the test, possible outcomes, and methods for communicating and maintaining confidentiality of results.
>
> Genetic testing is not considered a covered benefit for:
> - Criteria other than those outlined above.
> - Testing to confirm a diagnosis or disorder that can be diagnosed by conventional diagnostic methods.
> - Testing for conditions or purposes where the test results would not directly influence the management or treatment of the disease or condition (e.g., a disease without known treatment).
> - Testing for informational purposes or management of a beneficiary's family member.
> - Confirmatory testing for validation of laboratory results.
> - Screening for investigational or research purposes.
> - Minors under the age of 18 for adult onset conditions that have no preventative or therapeutic treatments.
> - Testing that has not been performed in a CLIA-certified laboratory.
> - The sole purpose of family planning counseling and infertility services.
>
> *Medicaid Provider Manual*
> *Laboratory Chapter*
> *July 1, 2015, pp 9-11.*

The Department's witness testified that Appellant's prior authorization request was denied as testing being requested was considered experimental and investigational and because the testing did not offer results that would directly influence the management or treatment of the Appellant's diseases or conditions.

Neither the Appellant or the Appellant's Representative offered testimony.

Based on the evidence and documentation submitted, Appellant did not prove, by a preponderance of evidence, that the Psych-Markers test requested was neither experimental or investigational or whether the results would directly influence the management or treatment of the Appellant's diseases or conditions.

Accordingly, the Department's denial must be upheld.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Corey A. Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

CAA/db

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