[redacted]
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Date Mailed: June 2, 2020
MOAHR Docket No.: 20-001001
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a telephone hearing was held on May 6, 2020. Dr. [redacted] appeared and testified on Petitioner's behalf. Latasha Girty, Appeals and Grievances Specialist, appeared and testified on behalf of Molina Healthcare of Michigan, the Respondent Medicaid Health Plan (MHP). Dr. Keith Tarter, Senior Medical Director, also testified as a witness for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-96. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for a continuous glucose monitor (CGM)?

FINDINGS OF FACT

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

1. Petitioner is a [redacted] ([redacted]) year-old Medicaid beneficiary who is enrolled in the Respondent MHP and who has been diagnosed with type 1 diabetes. (Exhibit A, page 40).

2. Due to her diabetes, Petitioner is on an insulin pump and she checks her blood glucose levels approximately four times a day. (Exhibit A, pages 11-15; Testimony of Petitioner's representative; Testimony of Respondent's Senior Medical Director).

3. However, she has not had any hypoglycemic events or hospitalizations; and, even with some occasional lower blood glucose levels at mealtimes, her diabetes is controlled. (Exhibit A, pages 11-15, 25; Testimony of Petitioner's representative; Testimony of Respondent's Senior Medical Director).

4. On November 15, 2019, Respondent received a prior authorization request submitted on Petitioner's behalf by her doctor for a CGM. (Exhibit A, pages 48-82).

5. On November 22, 2019, Respondent sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 85-92).

6. With respect to the reason for the denial, the notice stated:

> **The notes sent in show that your child has diabetes. A request was received for a Continuous Glucose Monitoring System. This a system that checks blood sugar on a continuous basis. To be approved, all of the criteria must be met. Your child must require insulin 3 or more times per day. And, your child must be unable to tell when she is having an event due to extremely low blood sugar. Or, there must be recent hospitalization or ER visits for seizures or other conditions due to low blood sugar. Or, your child must have a condition that affects very small blood vessels (such as in the eye). Or, your child must have recurrent acid build up in the blood (called ketoacidosis) due to high blood sugar. The notes do not show that the criteria have been met. Therefore, blood sugar monitoring system is denied.**
>
> **Criteria used: Michigan Department of Health and Human Services, Medicaid Provider Manual, Medical Supplier, 2.3.B. Continuous Glucose Monitoring Equipment And Supplies.**
>
> *Exhibit A, page 85*

7. On January 9, 2020, Petitioner filed an Internal Appeal with Respondent regarding the denial of the prior authorization request. (Exhibit A, pages

30-46).

8. As part of that appeal, Petitioner's doctor indicated that, while there may not have been enough "blood sugars" previously submitted, her office has been in contact with Petitioner's family over the past month and there is now documentation that Petitioner has been checking her blood sugars at least four times per day. (Exhibit A, page 34).

9. Petitioner's doctor also wrote that they are asking for reconsideration of the denial of the requested CGM as "it would be very useful for the patient and beneficial to her diabetes management, as she experiences frequent low blood sugars". (Exhibit A, page 34).

10. Respondent subsequently denied Petitioner's Internal Appeal. (Exhibit A, page 27; Testimony of Respondent's representative).

11. On February 18, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit A, pages 3-27).

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 one of those MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) 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 MDHHS 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) [CHANGE MADE 10/1/19]

The following services must be covered by MHPs:

* * *

- Durable medical equipment and medical supplies

MPM, October 1, 2019 version
Medicaid Health Plan Chapter, pages 1-2
(internal highlighting omitted)

Here, pursuant to the above policy and its contract with MDHHS, Respondent has limited coverage of CGMs to the applicable published Medicaid coverage and limitation policies set forth by MDHHS in the Medical Provider Manual (MPM).

With respect to the Standards of Coverage for CGMs, the MPM states in part:

A personal use CGMS and supplies are covered for persons with Type I diabetes when all the following are met:

- The beneficiary is under the care of one of the following:

  A. An endocrinologist; or

B. A physician or non-physician practitioner (nurse practitioner [NP], physician assistant [PA], or clinical nurse specialist [CNS]) who is managing the beneficiary's diabetes. (This provider must provide documentation that the beneficiary completed a Medicaid-covered certified diabetes self-management education [DSME] training program within one year prior to the written order);

- The beneficiary has Type I Diabetes requiring the administering of insulin three or more times per day or is currently using an insulin pump; and at least one of the following:

  - Is unable to consistently and reliably identify hypoglycemic events (e.g., hypoglycemic unawareness);
  - A recent history of hospitalization or emergency room visits for seizures or other conditions attributed to a hypoglycemic event;
  - Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);
  - The presence of microvascular complication (e.g., vasculopathy, retinopathy); or
  - Ketoacidosis or uncontrolled glucose.

  At least one of the above conditions must be documented (e.g., hypoglycemic unawareness).

- The beneficiary's treatment plan recommends testing blood glucose a minimum of four times per day;

- The beneficiary has poor diabetic control despite attempts to maximally optimize care (e.g., compliance) with hypoglycemic unawareness, seizures, unexplained hypoglycemic episodes, recurrent ketoacidosis, and/or HbA1c not in an acceptable range;

- The beneficiary's current treatment plan requires frequent adjustments to insulin dosage throughout the day;

- The endocrinologist/physician/non-physician practitioner documents beneficiary compliance with their treatment plan; and

- The beneficiary or his/her caregiver is educated on the use of the device and is willing and able to use the CGMS.

MPM, October 1, 2019 version
Medical Supplier Chapter, pages 30-31
(internal highlighting omitted)

Moreover, with respect to the documentation that must submitted in order for a CGM to be approved, the MPM also states in part:

> Documentation must be less than 90 days old and include all the following:
>
> - The order is written by the endocrinologist or other physician/non-physician practitioner treating the beneficiary;
>
> - Diagnosis related to the need for the CGMS;
>
> - Length of need;
>
> - Number of finger-stick tests beneficiary performs per day;
>
> - Frequency of insulin administered per day or if the beneficiary is using an insulin pump;
>
> - Records of hypoglycemic events, HbA1c levels, uncontrolled glucose, ketoacidosis, recent hospitalizations or emergency room visits related to conditions attributed to hypoglycemic events, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable;
>
> - Current treatment plan and beneficiary's compliance with the plan; and

- Documentation of beneficiary completion of a Medicaid-covered certified DSME training program (if provider other than an endocrinologist is treating the beneficiary's diabetes). The DSME training program must have been completed within one year prior to the written order for the CGMS and include education on the use of a CGMS. (Refer to the Hospital chapter of the Medicaid Provider Manual for additional information. The Medicaid Provider Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.)

The initial order must be written for six months. If the beneficiary continues to be compliant with use of the CGMS and treatment plan, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and receivers (following frequency rules below) may be written for a 12-month period.

Note: For CSHCS beneficiaries, a prescription from a pediatric endocrinologist is required for a CGMS.

MPM, October 1, 2019 version
Medical Supplier Chapter, page 31
(internal highlighting omitted)

As discussed above, Respondent denied a prior authorization request submitted on Petitioner's behalf for a CGM and upheld the denial following a Local Appeal.

Petitioner has now appealed that decision and, in doing so, bears the burden of proving by a preponderance of the evidence that the Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the applicable policies and relevant evidence in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

Among other requirements, the above criteria for the approval of a CGM requires that a beneficiary with type 1 diabetes have at least one of the following conditions: an inability to consistently and reliably identify hypoglycemic events; a recent history of hospitalization or emergency room visits for conditions attributable to a hypoglycemic event; a coexistent morbidity that poses an unusual challenge with concomitant

hypoglycemia; the presence of a microvascular complication; or ketoacidosis or uncontrolled glucose.

The medical documentation and testimony in this case demonstrate that Petitioner does not meet the applicable criteria for CGMs identified above and relied upon by Respondent. In particular, even if Petitioner has occasional low blood glucose levels, it is undisputed that Petitioner has no history of either severe hypoglycemia or a significant number of non-severe hypoglycemic episodes; her diabetes is under good control; and that Petitioner can both recognize symptoms of hypoglycemia and properly address them.

Rather than arguing that Petitioner meets the applicable criteria, Petitioner's representative/doctor testified that it is challenging for Petitioner as a teenager to maintain her insulin pump and frequently check her blood glucose levels, and that a CGM would benefit Petitioner greatly and improve her quality of life. However, even if that is true, the fact that Petitioner would benefit from the CGM does not make it medically necessary and Petitioner is still required to meet the applicable criteria.

Petitioner has therefore failed to meet her burden of proving that one of conditions identified by policy is present here or that she meets the applicable criteria, and Respondent's decision that Petitioner does not meet the requirements in policy for the approval of a CGM must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's prior authorization request for a continuous glucose monitor.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Managed Care Plan Division
CCC, 7th Floor
Lansing, MI
48919

Petitioner

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Community Health Rep

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