Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: March 14, 2025
Docket No.: 25-004449
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।
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DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on March 11, 2025. Meagan Schinella, Fair Hearings Officer, appeared on behalf of Respondent, Monroe County Mental Health Authority (Department). Kathleen Moore, Clinical Program Director, appeared as a witness for the Department. [redacted] Petitioner's Durable Power of Attorney, appeared on behalf of Petitioner.

Exhibits:

Petitioner	None
Department	A. Hearing Summary

ISSUES

Did Respondent properly deny Petitioners' requests for Enhanced Pharmacy Items?

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 Medicaid beneficiary who receives services from the Department as an intellectual with a developmental disability/cognitive

impairment and enrolled in the Habilitation Supports Waiver (HSW). (Exhibit A.)

2. Petitioner receives from the Department as part of his Individualized Plan of Service (IPOS), targeted case management, supports broker, enhanced pharmacy, community living supports (CLS), respite, and psychology. (Exhibit A; Testimony.)

3. Petitioner utilizes a self-directed services arrangement for the supports broker, enhanced pharmacy, CLS and respite which is managed by his mother/Power of Attorney.

4. On August 30, 2024, the Michigan Department of Health and Human Services sent Department an email indicating tissues are not a covered item under the Enhanced Pharmacy provisions as it is considered a remedy. (Exhibit A; Testimony.)

5. On September 6, 2024, Department sent Petitioner an adverse benefit determination denying coverage under the enhanced pharmacy benefit for non-latex gloves, hand sanitizer, extra soft tissues, and Huggies Natural Care Wipes. The Department had concluded these items did not qualify as an enhanced pharmacy benefit as they did not provide a direct medical or remedial benefit and were not listed among the allowable items in the Medicaid Provider Manual. (Exhibit A; Testimony.)

6. On September 13, 2024, the Petitioner submitted an internal appeal. (Exhibit A; Testimony.)

7. On October 4, 2024, the Department sent Petitioner an appeal decision upholding the initial denial. The denial stated the following:

> The Review Committee stated that the items you requested to be covered by Enhanced Pharmacy (hand sanitization items, tissues or "Kleenex", disposable wipes or "Huggies," and rubber or synthetic protective gloves) do not provide direct medical or remedial benefit as required in the Medicaid Provider Manual. The items in question do not fix, repair, or aid in healing a physical condition of Matthew's disability or illness.[1]

8. On January 28, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit A; Testimony.)

[1] Exhibit A, p 36.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.[2]

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.[3]

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.

> insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State . . .[4]

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioners have been requesting Enhanced Pharmacy Items through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.4.B. ENHANCED PHARMACY**
>
> Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.
>
> The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):
>
> - Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
> - First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)
>
> The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:
>
> - Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
> - Vitamins and minerals

[4] 42 USC 4396n(b).

- Special dietary juices and foods that augment, but do not replace, a regular diet

- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:

    - A history of aspiration pneumonia, or

    - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)[5]

Additionally, any service authorized through Department must be medically necessary. Regarding the required medical necessity, the MPM also provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
>
> - Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
>
> - Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or

[5] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2024, pp 153-154.

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

    - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

    - that are experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and/or

- Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.[6]

Here, as discussed above, Petitioner requested Enhanced Pharmacy items, and they have been denied on the basis that they failed to meet the Enhanced Pharmacy requirements found in the MPM.

In appealing those denials, Petitioners bear the burden of proving by a preponderance of the evidence that Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Department's decisions in light of the information it had at the time it made any decision.

Department argued the requested items did not provide Petitioner with direct medical or remedial benefit and additionally, were not listed among the allowable items. To strengthen their argument, they provided an email from the Department of Health and Human Services wherein the Department of Health and Human Services commented on the policy and confirmed that tissues themselves were not a covered item.

In Response, Petitioner argued these items had been provided in the past, and he was now being targeted and singled out due to his displeasure with the pharmacy providing the items. Petitioner also argued these items were prescribed by a physician and were part of his IPOS, and thus, they should be a covered benefit.

Given the record in this case, Petitioner has not met their burden of proving that Department erred, and consequently, Department's decisions must, therefore, be affirmed.

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2024, pp 13-14.

The fact Petitioner received an item or service in the past does not by itself determine whether Petitioner can or should continue receiving a service. Additionally, there was no evidence of the Petitioner being targeted or singled out. The Department identified the specific policy that applies and pointed out why the items would no longer be covered. Lastly, the fact the items were prescribed by a physician and part of Petitioner's IPOS is just one part of the coverage criteria. In addition to these requirements, the item must provide a direct medical or remedial benefit. In this case, this was not shown.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Department acted appropriately in denying Petitioners' request for additional Enhanced Pharmacy items.

IT IS THEREFORE ORDERED that:

- Department's denial of Petitioners' request for additional Enhanced Pharmacy items is **AFFIRMED**.

COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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