

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████

Appellant

_____ /

Docket No. 2010-16719 MCE
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing appealing the Department's denial of exception from Medicaid Managed Care Program enrollment.

After due notice, a hearing was held ██████████. ██████████ appeared on his own behalf. ██████████, Appeals Review Officer, represented the Department. ██████████, Enrollment Services Specialist, appeared as a witness for the Department.

ISSUE

Does the Appellant meet the requirements for a managed care exception?

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 a ██████████ Medicaid beneficiary.
2. The Appellant resides in ██████████. He is a member of the population required to enroll in a Medicaid Health Plan (MHP).
3. On ██████████, the Michigan Department of Community Health Enrollment Services Section received a managed care exception request from the Appellant's medical providers, neurologist ██████████ and his prosthesis supplier ██████████. (Exhibit 1, pages 8-9)

4. On ██████████, the Appellant's request for a managed care exception was denied. The denial notice indicated that ██████████ participates in at least one MHP available to the Appellant and that the Appellant was not receiving frequent and active treatment needed to allow for a Medical Exception. (Exhibit 1, pages 10-11)
5. On ██████████, the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's request for an Administrative Hearing. (Exhibit 1, page 7)

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 was notified of the Health Care Financing Administration's approval of its request for a waiver of certain portions of the Social Security Act to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Qualified Health Plans.

Michigan Public Act 131 of 2009 states, in relevant part:

Sec. 1650 (3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to mandatory enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

MDCH Medicaid Provider Manual, Beneficiary Eligibility Section, January 1, 2010, page 30, states in relevant part:

The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (M.D. or D.O.) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary

who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:

- the attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- the condition stabilizes and becomes chronic in nature, or
- the physician becomes available to the beneficiary through enrollment in a MHP.

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

MDCH Medicaid Provider Manual, Beneficiary Eligibility Section, January 1, 2010, pages 30- 31, states in relevant part:

Serious Medical Condition

Grave, complex, or life threatening

Manifests symptoms needing timely intervention to prevent complications or permanent impairment.

An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.

Chronic Medical Condition

Relatively stable

Requires long term management

Carries little immediate risk to health

Fluctuates over time, but responds to well-known standard medical treatment protocols.

Active treatment

Active treatment is reviewed in regards to intensity of services when:

- The beneficiary is seen regularly, (e.g., monthly or more frequently,) and
- The condition requires timely and ongoing assessment because of the severity of symptoms and/or the treatment.

Attending/Treating Physician

The physician (M.D. or D.O.) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.

MHP Participating Physician

A physician is considered participating in a MHP if he is in the MHP provider network or is available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with the MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.

The Appellant's request for medical exception indicates he is receiving treatment for chronic and ongoing medical conditions including right below elbow amputation with resulting phantom limb pain, left shoulder capsulitis with impingement, thoracic back pain, left carpal tunnel syndrome, chronic back pain, chronic depression/anxiety, dyslexia, and osteoarthritis. The requests also indicates he sees his doctor quarterly for visits and that he has an old prosthesis which he has not been able to have repaired. (Exhibit 1, pages 8-9) ██████████ did indicate that he participates in two MHPs. (Exhibit 1, page 8)

In reviewing the Appellant's medical exception request, the Department found that ██████████ does participate in at least one MHP available to the Appellant, ██████████ (Exhibit 1, pages 12-13) The Appellant has been enrolled in ██████████ since June 1, 2009. (Exhibit 1, page 10) Further, the Department determined that the quarterly visits do not meet the frequent and active treatment criteria as defined as monthly or more frequently in the Medicaid policy. The Department witness also noted that the request for the medical exception was received after the two month period allowed by the Medicaid policy.

The Department witness further testified that the second medical exception request was not provided by an MD or DO, but rather the Appellant's prosthetic care provider. The Department witness explained that the medical exception criteria does not include providers who are not MD's or DO's, however she stated that prosthetic care is available and covered under the Appellant's MHP.

Accordingly, the Department determined that the criteria for a Medical Exception has not been met as the doctor is available to the Appellant through the MHP and he does not meet the frequent and active treatment needed for a medical exception. (Exhibit 1, pages 18-19)

The Appellant disagrees with the Department's determination and testified that the hook on his prosthetic is broken. The Appellant stated that the local prosthetic clinic does not take ██████████ and will not help him.

The Department witness testified that the MHPs, such as ██████████, must provide the same services that would be available under the Fee-For-Services, or straight Medicaid. The Department witness suggested that the Appellant utilize a case manager, available through ██████████, to assist him with determining what prosthesis providers are covered and if he needs an authorization from his doctor. Additionally, the Department witness stated that the open enrollment period to change MHP's is coming up.

This ALJ reviewed the evidence of record. It does not establish that the Appellant is receiving frequent and active treatment for a serious medical condition, as defined in the above cited Medicaid policy, with a doctor who does not participate with a MHP. To the contrary, the evidence supports the Department's determination that the Appellant did not meet the criteria because his medical conditions are chronic and he is only going to the doctor quarterly. The Department further established that the doctor indicated on the medical exception request does participate in the MHP the Appellant is enrolled in. The evidence does not establish that the Appellant meets all the criteria necessary to be granted a managed care exception.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Appellant does not meet the criteria for Medicaid Managed Care exception.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: ██████████

[REDACTED]
Docket No. 2010-16719 MCE
Decision and Order

[REDACTED]
Date Mailed: 4/14/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.

