**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2010-36917 MCE
Case No. [redacted]

[redacted],

Appellant
_____/

## 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.*, following 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 [redacted]. The Appellant's mother, [redacted], represented the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], 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 ALJ, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] year-old Medicaid beneficiary. (Exhibit 1, page 9)

2. The Appellant resides in [redacted] Michigan. He is a member of the population required to enroll in a Medicaid Health Plan (MHP). He is currently enrolled in the Health Plan of Michigan (Exhibit 1, page 2; Testimony of Miller)

3. On [redacted], the Department received managed-care exception requests from the Appellant's audiologists. (Exhibit 1, pages 9-10)

4. On [redacted], the requests for a managed-care exception were denied. The denial notice indicated that the requests were denied because there was no information from an attending physician (M.D. or D.O.) and the Appellant is not receiving frequent and active treatment as defined in the Department criteria. (Exhibit 1, pages 7-8)

5. On [redacted], the State Office of Administrative Hearings and Rules for

the Department of Community Health received the Appellant's Request for Administrative Hearing. (Exhibit 1, page 6)

## 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 [redacted], 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 154 of 2005 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 one (1) of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to managed care 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, pages 30-31, state in relevant part:

> The intent of a medical exception 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 was 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 available only 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, whichever occurs first.

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.

**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

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

**Active treatment**

Active treatment is reviewed in regards to intensity of services.

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, the treatment, or both

The treatment or therapy is extended over a length of time.

**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 or she is in the MHP provider network or is available on an out-of-network basis with one of the MHPs for 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 medical-exception requests evidence that the Appellant is receiving treatment for a chronic and ongoing medical condition—bi-lateral cholesteatoma. However, the requests do not evidence frequent and active treatment as defined in the criteria set forth above. One request indicates that the Appellant is treating every six months; the other indicates every three months. The criteria states that treatment must be monthly or more frequently. Evidence of treatment that is frequent and active such that doctor visits are monthly or more often is consistent with the stated purpose and intent of the policy. In addition, the requests were made by audiologists, not an M.D. or D.O. as required by policy.

The Appellant's mother testified that she requested the hearing because she wants the Appellant to be able to treat with the doctors who performed his ear surgeries—Drs. [redacted] and [redacted]—and she would like to maintain continuity of care. She also stated that she is unhappy with the care provided by the MHP's doctors.

While this ALJ sympathizes with the Appellant's situation, the evidence establishes that the medical-exception request was not made by an M.D. or D.O.[1] as required by policy and that the Appellant is not receiving the frequent and active treatment to qualify for a medical exception. The Department must rely on what was provided on the forms submitted and make their determination within the bounds of policy. Further, the burden of proof rests with the Appellant to establish that the Department's decision is incorrect. The Appellant

1 This ALJ did receive medical records after the hearing from [redacted], M.D., and [redacted], M.D. However, these records also do not support the frequent and active treatment required to meet the medical-exception criteria, as the Appellant is only treated by those doctors every four to six months. (Exhibit 2)

has not met this burden. Accordingly, the request for exception from Medicaid managed care was properly denied.

## DECISION AND ORDER

The ALJ, 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.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/21/2010

***** 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.