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. 2010-39450 QHP

[redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on her own behalf. [redacted], Customer Services, represented the Medicaid Health Plan (MHP), [redacted]). [redacted] MHP Quality Review Specialist, appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny a prior approval requesting coverage for an out-of-network physician consultation?

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 Medicaid eligible and is subject to the Medicaid managed care program and to program conditions.

2. The Appellant is enrolled in the PHP Medicaid Health Plan and was enrolled on [redacted].

3. The Appellant is a [redacted] woman with a history of paroxysmal atrial fibrillation. She has also been diagnosed with new onset hyperthyroidism and dyslipidemia. (Exhibit 1,page 2)

4. On [redacted], the MHP received an out of network request form from the Appellant's physician for an office consultation and electrocardiogram with [redacted]. (Exhibit 1, page 1 and Exhibit 2)

5. On [redacted], the MHP denied the request because the services are available within the MHP's network of providers. (Exhibit 1, page 36)

6. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's request for an administrative hearing. (Exhibit 3)

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 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 Medicaid Health Plans (MHP).

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). **The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.** (Bold added by ALJ).
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, FY 2008.*

The Medicaid Provider Manual addresses MHP coverage of out of network providers:

> **2.6 OUT-OF-NETWORK SERVICES**
>
> **2.6.A. PROFESSIONAL SERVICES**
>
> With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services; and
- Tuberculosis services.

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for service (FFS) rates in effect on the date of service.

Medicaid Provider Manual,
Medicaid Heal Plans Section,
April 1, 2010, Page 5.

None of the above listed exceptions were present in the Appellant's case. The MHP's requirement for obtaining prior authorization for coverage of out of network provider services is consistent with the Medicaid policy.

The Appellant testified that her current cardiologist recommended the referral to [redacted] to determine in a cardiac ablation surgery would be warranted because he does not perform this procedure. The requested services were listed by CPT coverage code, 99243 and 93000. (Exhibit 1, page 1) These are the CPT codes for an office consultation for a new or established patient requiring a detailed history, detailed examination, and medical decision making of low complexity, as well as an electrocardiogram, routine ECG with at least 12 leads, with interpretation and report. (Exhibit 2)

The MHP explained that the Appellant's out of network provider request was denied because the requested services are available within the MHP's network. The MHP also explained that the Appellant's recent diagnosis of hyperthyroidism is suspect as contributing to previous heart problems. However, as the Appellant is still in the diagnostic phase for this, the further cardiac workup is not needed at this time. The MHP stated that they would re-consider the Appellant's request, if the cardiac services are still needed and no in-network providers are available, once the diagnostic phase is completed. The Appellant testified that she hoped her condition could be controlled with medication and that the ablation procedure would not be needed.

The MHP's policy is consistent with Medicaid policy, the denial of the out of network provider request for an office consultation and electrocardiogram is affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied Appellant coverage for an out-of-network physician visit.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 9/10/2010

***** 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 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.