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:

[redacted]

Appellant

_____/

Docket No. 2011-13415 DISC
Case No. 9379008

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 [redacted]. [redacted] represented herself at hearing.

[redacted] represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's request to receive Special Disenrollment-For Cause from a Managed Care Program?

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 [redacted] Medicaid Beneficiary who is enrolled in [redacted] a Medicaid Managed Health Care Plan (MHP). She has been enrolled since at least [redacted].

2. On [redacted], the Department received the Appellant's Special Disenrollment-For Cause request, which indicates that she wants to dis-enroll from [redacted].

3. The Appellant asserts she is unable to obtain the MRI and shoulder surgery she requires.

4. The Appellant did not submit any evidence that she is unable to access medical care, is not being provided necessary medical services or is undergoing frequent and active treatment for a serious medical condition with a doctor who is no longer participating.

5. The Appellant's testimony establishes she is treating with orthopedic specialists and that she was informed she did not satisfy the prior authorization criteria for the procedures she has sought.

6. The Appellant's testimony establishes she is dissatisfied with the prior authorization process and requirements she has been subjected to as a member of [redacted].

7. The Department of Community Health sought information from [redacted] in conjunction with the Appellant's request for special disenrollment. It was informed that the Appellant had sought an MRI and been denied after her provider failed to submit follow up information sought so that a determination could be made concerning prior authorization criteria for the MRI.

8. On [redacted], the Department denied the request from the Appellant.

9. On [redacted], the Department received the request for a formal, administrative hearing.

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.

> The Department of Community Health, pursuant to the provisions of the Social Security Act Medical Assistance Program, contracts with the Medicaid Health Plan (MHP) to provide State Medicaid Plan services to enrolled

> beneficiaries. The Department's contract with the MHP specifies the conditions for enrollment termination as required under federal law:
>
> 12. Disenrollment Requests Initiated by the Enrollee
>
> (b) Disenrollment for Cause
>
> The enrollee may request that the Department review a request for disenrollment for cause from a Contractor's plan at any time during the enrollment period to allow the beneficiary to enroll in another plan. **Reasons cited in a request for disenrollment for cause may include: information that shows you have a serious medical condition that is under active treatment form a doctor who does not participate with the health plan in which you are currently enrolled; lack of access to providers or necessary specialty services covered under the Contract or concerns with quality of care; and lack of access to primary care within 30miles/30 minutes of residence. Beneficiaries must demonstrate that appropriate care is not available by providers within the Contractor's provider network or through non-network providers approved by the Contractor.** (Bold emphasis added by ALJ)
>
> *MDCH/MHP Contract, Section I2- (b), Fiscal year 2010*

Both the special disenrollment request form filled out by the enrollee and the Medicaid Health Plan contract language give details about the criteria that must be met in order for an enrollee's request for special disenrollment to be granted. The special disenrollment request form filled out by the enrollee has an "INSTRUCTIONS" section at the top of the first page. Bullet numbers three and four of six-bullet points state:

- Attach documentation from your doctor to support your request.
- **If you cannot obtain information from your doctor(s), on a separate sheet of paper, state why and give your doctor's name, telephone number**

and the office address so that we can follow up with them.

In this case, the Department received Appellant's Special Disenrollment-For Cause request, which indicates that she wants to disenroll from [redacted] due to denial of MRI which she asserts interferes with her ability to obtain the surgery she believes she needs on her left shoulder. The Department sought information from [redacted] in conjunction with the request to disenroll. [redacted] submitted documentation indicating a prior authorization request was received (for the MRI) and additional information was sought from the provider. The MHP indicated there was no documentation that anti-inflammatory drugs treatment had been attempted and failed and that physical therapy had also failed. It was indicated they were necessary prior to approving the request for an MRI. The medical provider was asked to submit additional documentation regarding anti-inflammatory medication and physical therapy. The plan did not hear back from the provider, thus the request was ultimately denied. Department witness stated that the information submitted by the Appellant and MHP did not establish she met any of the criteria to disenroll for cause.

The Appellant asserted her provider had submitted 14 pages of documentation to the health plan, which they ignored. She said they changed the prior authorization criteria from the past and she does not want to have to go through all of this. She further stated her medical records indicate she cannot take anti-inflammatory medication due to internal and rectal bleeding. She stated she already had the surgery on her right shoulder, she got an MRI without difficulty and she should be able to do the same for her left shoulder.

This ALJ has considered the testimony and documentation from both witnesses. The Appellant's testimony establishes she has not been approved for a procedure she believes she needs. It does not establish she meets the Department criteria for approving a for cause special disenrollment, however. While this ALJ can sympathize with the difficulties in gaining prior authorization for certain medical procedures, the imposition of prior authorization criteria does not establish she is being denied access to specialty medical care. Nor is she undergoing active treatment for a serious medical condition with a provider who no longer accepts [redacted]. In fact, her testimony establishes she is able to obtain the specialty orthopedic care from the providers. It is undisputed she has not been approved for the MRI she sought, however, again, this alone does not satisfy the criteria needed to approve a request for special disenrollment. The reasons for denial of the prior authorization for the MRI are disputed. There is insufficient evidence to find the MRI denial constitutes lack of access to needed care. The Appellant did not present any documentation to support the claim her provider had satisfied all the prior authorization criteria for obtaining an MRI on her behalf, thus this ALJ cannot find the evidence sufficient to have persuasive effect.

The Department's denial of the request for Special Disenrollment must be upheld. The Appellant failed to provide any evidence that she meets the eligibility criteria for a

Special Disenrollment-For Cause. The Department witness testified that the Appellant will be able to change her health plan without cause and without providing documentation of reason or need during open enrollment, in May of this year.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for Special Disenrollment-For Cause from the Managed Care Program.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/25/2011

***** 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.