STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-54386 ABW
Case No. 52911047

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted] appeared on his own behalf. [redacted], RN, Quality Assurance Manager, represented [redacted] County Patient Care Management System Health Plan, a County-Administered Health Plan (CHP).

ISSUE

Did the County Health Plan properly deny Appellant's request for retrospective out of network office visits dated [redacted]?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is enrolled in the County Health Plan as an Adult Benefit Waiver beneficiary.

2. The CHP contracts with the County Health Plan to provide services covered by the Adult Benefits Waiver.

3. Appellant is a [redacted] year-old male, born [redacted]. (Exhibit 2, p 5).

4. On [redacted], the County Health Plan notified Appellant that his request for retrospective out of network office visits from [redacted] through [redacted] was denied because prior authorization was not obtained prior to seeing an out of network doctor. (Exhibit 2, p 1). The denial contained a notice of Appellant's rights to a Medicaid Fair Hearing. (Exhibit 2, p 2)

5. On [redacted], the Department of Community Health (DCH) received the Appellant's request for an Administrative Hearing. (Exhibit 2, p 3).

CONCLUSIONS OF LAW

On [redacted], the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.

The Department's policy with regard to the Adult Benefits Waiver is found in the Medicaid Provider Manual:

> **SECTION 1 – GENERAL INFORMATION**
>
> This chapter applies to all providers.
>
> The Adult Benefits Waiver (ABW) provides health care benefits for Michigan's childless adult residents (age 19 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum copayments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.
>
> **SECTION 1.1 COUNTY-ADMINISTERED HEALTH PLANS**
>
> ABW beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs. An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:
>
> - Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program. Emphasis added.

> - Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable copayments.
>
> CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.
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> *Medicaid Provider Manual, Adult Benefits Waiver, October 1, 2011, Page 1.*

The CHP representative stated that it implements the ABW program consistent with Department Medicaid policy. The CHP representative testified and submitted evidence that its coverage policy is consistent with the Department's Medicaid policy, which explicitly states that CHP may require that services be provided through their contracted provider network and may institute prior authorization requirements. The CHP representative testified that their particular CHP requires that all covered services must be provided by the health plan and that any out of network services must receive prior authorization. The CHP representative testified that in the present case, the Appellant did not obtain prior authorization to receive out of network medical services, including allergy shots with [redacted], M.D.

The Appellant citied several state and federal laws, including the Elliott Larson Civil Rights Act, and requested that this Administrative Law Judge over-rule the ABW program's denial of reimbursement for the out of network services he received.

The CHP denial of Appellant's out of network services, obtained without prior authorization is consistent with Medicaid policy. The CHP and this Administrative Law Judge are bound by Department Medicaid policy, and neither can over-rule state and federal law and policy. As such, the CHP is not required to provide coverage for out of network medical services received without prior authorization. For these reasons the CHP's denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the County Health Plan properly denied Appellant's request for retrospective out of network office visits dated [redacted] through [redacted].

IT IS **THEREFORE ORDERED** THAT:

The County Health Plan's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date mailed 10/21/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.