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. 2011-8005 MCE
Case No. 18144257

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] appeared on her own behalf. [redacted] appeared as a witness for the Appellant. [redacted], represented the Department. [redacted], 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 [redacted] Medicaid beneficiary.

2. The Appellant resides in [redacted] Michigan. She is a member of the population required to enroll in a Medicaid Health Plan (MHP).

3. On [redacted], the Michigan Department of Community Health Enrollment Services Section received a managed care exception request from the Appellant's medical provider, [redacted]. (Exhibit 1, page 7)

4. On [redacted], the Appellant's request for a managed care exception was denied. The denial notice indicated that specialists from the

[redacted] accept referrals from all of the health plans, the information provided by the doctor described standard treatment for chronic on-going medical condition(s) or the routine monitoring of on-going medical condition(s), and what was sent in did not show that the Appellant was receiving frequent and active treatment needed to allow for a Medical Exception. (Exhibit 1, pages 8-9)

5. 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 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 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 she had left total hip arthroplasty on [redacted], and right total hip arthroplasty with [redacted]. Her current status includes right greater thochanteric bursitis status post total hip arthroplasty with a treatment plan of physical therapy. The request also indicates that the number of months to complete treatment and frequency of visits can not be determined at this time. (Exhibit 1, page 7)

In reviewing the Appellant's medical exception request, the Department considered that [redacted] is a specialist with the [redacted]. Specialists at the [redacted] accept referrals from all of the Medicaid Health Plans (MHP). ([redacted] Testimony) Further, the Department determined that the information provided by the Appellant's doctor did not establish the frequent and active treatment of a serious medical condition as defined in the Medicaid policy. Accordingly, the Department determined that the criteria for a Medical Exception had not been met as the doctor is available to the Appellant through a referral from a MHP and the information provided did not establish that she is receiving frequent and active treatment of a serious medical condition. (Exhibit 1, pages 8-9)

The Appellant disagrees with the Department's determination and testified that she has had trouble obtaining authorizations for her appointments and testing from the MHPs she has been enrolled in. However, it is noted that she was only enrolled in [redacted] from [redacted]. The Appellant then switched to [redacted] effective [redacted]. She also testified that she had not asked [redacted] about

authorization to see [redacted]. The Appellant's [redacted] testified he is concerned about the Appellant's health and noted their prior experience with HMO's in [redacted] refusing to let the Appellant consult with different doctors about her problems. He also explained that they can not afford to pay for office visits to [redacted] out of pocket.

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 her medical conditions are chronic as defined in the Medicaid policy and no evidence of the frequency of visits was submitted. The Department explained that the specialists at the [redacted] accept referrals from any of the MHP's and suggested that the Appellant ask for a case manager with her current MHP to help set up her care needs. The evidence does not establish that the Appellant meets 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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/17/2011

***** 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 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.