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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-42758 QHP
[redacted]

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] mother, represented the Appellant. [redacted], was represented by [redacted], Staff Attorney, and [redacted], Director of Member Services. [redacted] is a Department of Community Health contracted Medicaid Health Plan (MHP). [redacted], Medical Director, appeared as a witness for the MHP. The hearing record was left open through [redacted] to allow both parties to submit additional documentation, which has been received.

ISSUE

Did the MHP properly deny the Appellant's request for a referral to see an out of state physician at [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. The Appellant is a [redacted]-year-old Medicaid beneficiary and is enrolled in an MHP.

2. On or about [redacted], the MHP received a request for a referral for the Appellant to see an out of state physician at [redacted] for a diagnosis of Superior Mesenteric Artery Syndrome ("SMAS"). (Exhibit 3)

3. In [redacted] the MHP received documentation from the [redacted]. The Appellant was evaluated there in [redacted], including an upper GI Study, which did not show any evidence of SMAS. (Exhibit 1, pages 37-40)

4. On [redacted], the MHP issued a letter to the Appellant indicating the referral request to see an out of state physician at [redacted] was denied because the MHP's Medical Policy for non-emergent out of state services, coverage for elective services at out of state facilities and non-contracted facilities is only considered a benefit if the requested services are not available within the state of [redacted] The MHP requires documentation from [redacted] state facilities stating they are unable to provide services for the condition prior to consideration for coverage. (Exhibit 1, pages 43-48)

5. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf. (Exhibit 1, pages 3-33)

6. The MHP completed an internal review. [redacted] the MHP issued a letter to the Appellant indicating the determination to deny the non-emergent out of state services was upheld by the MHP. (Exhibit 1, pages 50-54)

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.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through

Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

....

Contract, *Supra,* p. 49

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) state:

> **7.3 OUT OF STATE/BEYOND BORDERLAND PROVIDERS [CHANGES MADE 7/1/12 & 10/1/12]**
>
> Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDCH reimburses out of state providers who are beyond the borderland area (defined below) if the service meets one of the following criteria:
>
> - Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
> - Medicare and/or private insurance has paid a portion of the service and the provider is billing MDCH for the coinsurance and/or deductible amounts; or
> - The service is prior authorized by MDCH. MDCH will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.
>
> ***
>
> Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services.
>
> MDCH Medicaid Provider Manual,
> General Information for Providers Section,
> October 1, 2012, page 13

The DCH-MHP contract provisions also allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the MHP's Policy and Procedure Manual, Review of Non-Emergent Out of State Services. (Exhibit 1, pages 55-60) Specifically for MHP members in Michigan, the policy states:

> ***Michigan***
>
> Comparable care (the term "comparable care" does not require that the services be identical) for the qualifying diagnosis cannot be provided within the State of Michigan

1. There must be documentation from at least two (2) in state tertiary care centers noting that they are unable to treat the member's condition, and that they are recommending that the member go to an out of state provider for necessary medical care.

2. Acceptable tertiary care centers include the University of Michigan, the Michigan State University, Detroit Medical Center/Wayne State University, William Beaumont Hospital, Henry Ford Hospital, DeVos Children's Hospital, Spectrum Grand Rapids.

(Exhibit 1, page 58)

These criteria are consistent with the Medicaid standard of coverage to only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

On or about [redacted], the MHP received a request for a referral for the Appellant to see an out of state physician at [redacted] for a diagnosis of SMAS. (Exhibit 3) The MHP asserted that the denial was appropriate because there has not been documentation from [redacted] tertiary care centers stating the requested out of state services are not available in the [redacted] Further, the MHP noted that while the request listed the diagnosis of SMAS, there was additional evaluation at the [redacted], including an upper GI Study that did not show any evidence of SMAS. (Exhibit 1, pages 37-40)

The Appellant's mother disagrees with the denial and provided detailed testimony of the Appellant's relevant treatment history. In particular, the Appellant's mother stated that the GI Study at the [redacted] was abnormally short and asserted this was not a complete study to be able to diagnose anything. Further, the recommendations from the [redacted] physician have already been tried and were unsuccessful. The Appellant has continued to have frequent hospitalizations and excessive vomiting. The Appellant's mother is understandably concerned that the Appellant will be further compromised while waiting for further consideration of sending the Appellant for treatment. (Mother Testimony) The Appellant's mother submitted additional medical documentation with the request for hearing and after the [redacted] telephone hearing proceedings. (Exhibit 1, pages 3-33; Exhibit 4)

The documentation submitted for the [redacted] referral request was insufficient to establish the medical necessity for the Appellant to see an out of state physician at [redacted] for a diagnosis of SMAS. There is not documentation from two tertiary care centers noting that they are unable to treat the Appellant's condition, and that they are recommending that the member go to an out of state provider for necessary medical care. Accordingly, the MHP's determination must be upheld based on the available information.

However, as the Appellant continues to receive medical care, a new referral request can be made at any time with supporting documentation.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant's request for a referral to see an out of state physician at [redacted].

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

***** 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.