

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:

Docket No. 2013-62360 QHP

██████████

██████████

██████████

Appellant

_____ /

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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held ██████████ appeared and testified. ██████████, Appeals Coordinator, represented ██████████, the Medicaid Health Plan (MHP). ██████████ Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for out of network chiropractic services?

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 █████ year old female Medicaid beneficiary who is currently enrolled in the Respondent MHP.
2. On or about ██████████, the MHP received a Prior Authorization request for chiropractic services from ██████████ Chiropractic. (Exhibit A, p. 4).
3. On ██████████ the MHP sent a denial notice to the Appellant, stating that the Prior Authorization request was denied because: the chiropractic services were out of network services; the services requested may be obtained by a ██████████ network provider; and there is no evidence that services are not able to be provided by a Par provider within Appellant's local area. (Exhibit A, p. 23).

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4. On [REDACTED], the Appellant's Request for Hearing, protesting the denial, was received by the Michigan Administrative Hearing System.

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.

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 coverage(s) and limitations. (Emphasis added by ALJ)* 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 1-Z.

*Article II-G, Scope of Comprehensive Benefit Package.
MDCH contract (Contract) with the Medicaid Health Plans,
September 30, 2004.*

The major components of the Contractor's utilization management plan 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.

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- 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 Contractor must establish and use a written prior Approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverage(s) 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

*Article II-P, Utilization Management, Contract,
September 30, 2004.*

The aforementioned contract between the Department and the MHP states that the MHP must "operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations." The contract allows an MHP to make an out-of-network referral if it is medically necessary, for example, if the MHP did not have a chiropractic in its network that was able to provide Appellant with the medical treatment that she needs. (See Article II-H (2), Utilization Management, September 30, 2004) Appendix A 26 of the MHP's certificate of coverage also allows for out-of-network referrals if the services are medically necessary, and there is no in-network provider. Additionally, the Medicaid provider manual contains many provisions where prior authorization is mandatory for certain services. The MHP's certificate of coverage clearly and unambiguously states:

Services provided by out-of-network providers are covered if medically necessary, authorized by the Plan, and could not reasonably be obtained by a network provider, inside or outside of the State of Michigan, on a timely basis. (Appendix A 26)

The Michigan Department of Community Health (MDCH) Medicaid Provider Manual, section 1.9 (Prior Authorization), states:

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Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility.

*Medicaid Provider Manual, Practitioner Section,
Effective July 2013.*

In this case, the MHP established that it properly denied Appellant's request for chiropractic services provided by the out-of-network provider. The preponderance of evidence fails to establish that the chiropractic services or specific medical treatment that Appellant is requesting cannot be provided by a [REDACTED] participating provider. The Department provided evidence to establish that there is a par chiropractor within [REDACTED] miles or [REDACTED] minutes from Appellant's home. Appellant testified that she was not aware of this or informed of this by the MHP.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for chiropractic services provided by an out-of-network provider.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

/s/
Marya A. Nelson-Davis
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

MAND/db

cc: [REDACTED]

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***** 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.