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. 2013-69133 PA

[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.*, and upon a request for hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted], Appeals Review Officer, represented the Department of Community Health. [redacted], Review Coordinator, and [redacted], Medical Director, from the Michigan Peer Review Organization (MPRO) testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's prior authorization request for an inpatient hospital admission?

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 a [redacted] year-old Medicaid who has been diagnosed with Cystic Fibrosis. (Respondent's Exhibit A, pages 4-5).

2. The Department contracts with MPRO for MPRO to conduct telephonic and electronic authorizations of specified medical supplies and services. (Testimony of [redacted]).

3. In [redacted], Appellant was scheduled for an inpatient sinus surgery on [redacted]. (Testimony of Appellant's representative).

4. On [redacted] MPRO received a telephonic prior authorization request from the office of Appellant's doctor for the inpatient sinus surgery. (Testimony of [redacted]).

5. The nurse reviewer who took the call referred it to physician reviewer [redacted] and [redacted] determined that, while the surgery itself should be approved, the inpatient admission should be denied. (Testimony of [redacted].

6. MPRO then informed Appellant's doctor's office of the decision, as well as the opportunity for immediate reconsideration. (Testimony of [redacted]).

7. No request for reconsideration was submitted to MPRO within three days, as required by policy for immediate reconsideration. (Testimony of [redacted]).

8. Accordingly, on [redacted], the Department sent written notice of the denial of inpatient admission to Appellant's parents. (Respondent's Exhibit A, pages 16-17).

9. Specifically, that notice provided that the service of "Inpatient Admission" was being denied and that:

> The reason for this action is the physician reviewer determined that the admission and/or procedure are not medically necessary. The documentation did not support symptomatology that would warrant an acute care admission/procedure. Therefore authorization for the admission has been denied.

Respondent's Exhibit A, page 16

10. The denial notice also provided a number for Appellant to call if there were any questions about the denial. (Respondent's Exhibit A, page 17).

11. Appellant underwent inpatient sinus surgery on [redacted] (Testimony of Appellant's representative).

12. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on behalf of the minor Appellant. (Respondent's Exhibit A, pages 3-5).

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.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM). Regarding the specific request in this case, the applicable version of the MPM states in part:

> ### SECTION 9 – INPATIENT HOSPITAL AUTHORIZATION REQUIREMENTS
>
> The information in this section applies to instate and borderland hospitals. Information regarding out-of-state hospital authorization requirements can be found in the Out-of-State/Beyond Borderland Providers subsection of this chapter.
>
> All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician/dentist should refer to the Prior Authorization Certification Evaluation Review (PACER) subsection of this chapter for specific requirements.
>
> Medicaid does not cover services related to inappropriate or unnecessary inpatient admissions. This includes:
>
> - all elective admissions, readmissions, and transfers that are not authorized through the PACER system;
> - admissions or readmissions which have been inappropriately identified as emergent/urgent;
> - selected ambulatory surgeries inappropriately performed on an inpatient basis; and
> - any other inpatient admission determined to have not been medically necessary.

Medicaid does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), and diagnostic x-rays
- Observation
- Occupational Therapy (OT)
- Patient education
- Physical Therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction or weight control (unless prior authorized)

If Medicaid does not cover the services of the physician/dentist or hospital, the physician/dentist or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representative.

9.1 PRIOR AUTHORIZATION CERTIFICATION EVALUATION REVIEW (PACER)

Elective admissions, all readmissions within 15 days of discharge, continued stays (when appropriate), and all transfers for surgical or medical inpatient hospital services to and from any hospital enrolled in the Medicaid program

require authorization through the ACRC. This includes transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital. All cases are screened using the Medicaid approved Severity of Illness/Intensity of Services (SI/IS) criteria sets and the clinical judgment of the review coordinator. An ACRC physician/dentist makes all adverse decisions.

The ACRC performs medical/surgical and rehabilitation admission, readmission, and transfer reviews through the PACER system and assigns PACER numbers.

The attending/admitting physician/dentist or representative is responsible for obtaining the PACER number before admitting, readmitting, or transferring the beneficiary, with exceptions as noted below. (Refer to the Directory Appendix for PACER authorization contact information.)

The physician/dentist is responsible for providing the PACER number to the admitting hospital. The PACER number is issued on the day that the admission is approved by the ACRC. This number is valid for the entire medical or surgical admission unless otherwise noted in this section. PACER authorization must be requested prior to the admission of the beneficiary.

Physicians/dentists are asked to provide the procedure code(s) when a surgical admission/readmission is requested.

Authorization through the ACRC for the hospital admission does not remove the need for prior authorization (PA) required by Medicaid for specific services. The PA for the service must be obtained before the ACRC authorization is requested.

* * *

Approval of an admission only confirms the need for services to be provided on an inpatient hospital basis. Payment for the admission is subject to eligibility requirements, readmission, and third party liability (TPL) reimbursement policy, along with any pre- and post-payment determinations of medical necessity.

> If an admission, readmission, transfer, or continued stay is not approved, MDCH does not reimburse for services rendered. Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.
>
> **Reconsiderations**
>
> The attending physician/dentist or the hospital may request reconsideration of the adverse determination of the ACRC regarding the need for admission, readmission, transfer, or continued stay. This reconsideration right applies regardless of the current hospitalization status of the beneficiary. Reconsiderations must be requested within three business days of the adverse determination. (Refer to the Directory Appendix for ACRC contact information.) If requested by the ACRC, the provider must provide written documentation. The provider is notified of the reconsideration decision within one business day of receipt of the request or the date of receipt of written documentation. If the initial adverse determination is overturned, the adverse determination is considered null and void. If the initial adverse determination is upheld or is modified in such a manner that some portion of the hospital care is not authorized, the hospital is liable for the cost of care provided from the date of the initial determination, unless this determination is overturned in the Medicaid appeals process.
>
> *MPM, July 1, 2013 version*
> *General Information for Providers Chapter*
> *pages 17-19*

Therefore, based on the above policy, an elective inpatient admission such as the one at issue in this case must be both medically necessary and authorized by the Department prior to admission.

In this case, the Department denied the inpatient admission on the basis that it was not medically necessary. As testified to by [redacted] the sinus surgery requested in this case is typically performed as an outpatient procedure and the physician reviewer's notes regarding the review of prior authorization request failed to identify any basis for an inpatient admission. [redacted] also testified that, if there had been complications from the outpatient surgery, Appellant could have always been admitted to the hospital as needed.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying her prior authorization request.

Here, Appellant's representative first testified that the sinus surgery performed on [redacted] was Appellant's fourteenth surgery and, while most of those surgeries have been outpatient procedures, she was told by Appellant's doctors that this sinus surgery had to be an inpatient procedure.

However, Appellant's representative offers no support for her assertion that an inpatient admission was necessary and, while she did submit letters from Appellant's doctors stating that the sinus surgery itself was necessary, those letters do not address or justify any inpatient admission.

According to Appellant's representative, the letters do not address the inpatient admission as she and Appellant's doctors were unaware that it was only the inpatient admission that was denied and instead believed that the entire procedure had been denied. Nevertheless, MPRO informed the requesting doctor's office that only the inpatient admission was denied and the denial letter only states that the "Inpatient Admission" was being denied as not medically necessary and that "authorization for the admission has been denied." Moreover, to the extent there was any confusion, the denial notice also provided a number for Appellant to call if there were any questions about the denial.

As discussed above, Appellant bears the burden of proving that the Department erred and, given the lack of any evidence supporting Appellant's position in this case, she failed to meet that burden.

Appellant's representative also argues that Appellant and her family should not be held responsible for the costs of the inpatient admission given that, as far as they knew, the inpatient surgery was properly scheduled and approved. According to Appellant's representative, the sinus surgery was scheduled three months in advance; she relied on the doctors' representations that an inpatient procedure was necessary; and no one ever informed her that a prior authorization request had been made or denied.

However, even if true, those claims are beyond the scope of this hearing as this Administrative Law Judge only has jurisdiction over the Department's denial of the prior authorization request for inpatient admission, which appears to be proper based on the record. Appellant's doctors may have waited until days before the surgery to seek prior authorization; failed to inform Appellant's family about the denial; and gone ahead with the surgery even after the prior authorization request was denied, but those actions do not affect the propriety of the Department's actions.

Accordingly, this Administrative Law Judges finds that Appellant and her representative have failed to meet their burden of proof and that the Department's decision to deny the prior authorization request for inpatient admission must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Appellant's prior authorization request for an inpatient hospital admission.

IT IS THEREFORE ORDERED THAT:

The Department's decision is **AFFIRMED**.

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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.