

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2013-69750 QHP  
Case No ██████████

**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 telephone hearing was held on ██████████. ██████████, Appellant, personally appeared and testified. ██████████ (MHP) of ██████████ was represented by ██████████, Appeals Coordinator. ██████████, MD, Medical Director for the MHP appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny the Appellant's request for physical therapy (PT) with an out of network provider?

**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 male Medicaid beneficiary, a recipient of SSI.
2. On or about ██████████, the MHP received a request from ██████████, Inc. of ██████████ along with Appellant's physician's ██████████ Rx for PT "2-3 X /week for 8 weeks." (Exhibit I.14-18) Ultimate Rehab Services is a nonparticipating/out of network provider with the MHP.
3. On ██████████, the MHP issued a denial letter to the Appellant and her doctor denying the request on the grounds that the request for PT was by an out of network provider and that service may be obtained by an in network provider based on the MPH's Certificate of Coverage, Appendix A, paragraph 26, p 73. (Exhibit I.2,3)

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4. The MHP submitted evidence that there are over 100 physical therapists' from which Appellant may choose within 25 miles and 30 minutes of his home address. (Exhibit I.4-13)
5. On [REDACTED], the Appellant's appeal request was received by MAHS.

**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 MHPs.

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. 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.

*Section 1.022(E)(1), Covered Services.  
MDCH contract (Contract) with the Medicaid Health Plans,  
October 1, 2010.*

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.

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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 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.

*Section 1.022(AA), Utilization Management,  
MDCH contract (Contract) with the Medicaid Health Plans,  
October 1, 2010*

Unrefuted testimony on the record is that the MHP's contract was approved by the Department. Specifically, in this case, the MHP contract states:

Appendix A – Benefit Detail of Covered Services

...26. Out-of-Network Services. 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, insider or outside the State of Michigan, on a timely basis. Pgs 72, 73 (Exhibit I. 2,3)

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In this case, the DCH-MHP contract provisions allow Prior Approval procedures for utilization management purposes. The MHP Manager of Medicaid explained that the MHP's contract with the Department and their Certificate of Coverage require a member to obtain medical services from providers within their network of providers. Services will be approved by the MPH for a non-participating provider only if the type of services requested is not available from a participating provider. The MHP submitted evidence of over 100 participating providers within 25 miles and 30 minutes of Appellant's residence. Accordingly, the MHP denial of Appellant's request for PT by an out of network provider was consistent with the contract, Medicaid policy and thus, must be upheld.

**DECISION AND ORDER**

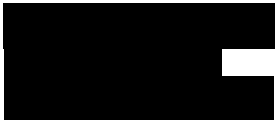
The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for Physical Therapy by a non-participating/out-of-network provider.

**IT IS THEREFORE ORDERED** that:

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

  s\  
\_\_\_\_\_  
Janice Spodarek  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

cc:



Date Signed: January 10, 2014

Date Mailed: January 10, 2014

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System 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.