STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 14-010758 HMS

[redacted], [redacted] [redacted]

Appellant

[redacted]/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 on Wednesday, [redacted]. [redacted] Appellant's mother and authorized hearings representative appeared and testified on the Appellant's behalf. [redacted], Customer Service appeared and testified on behalf of the Medicaid Health Plan (MHP), Physicians Health Plan (PHP) FamilyCare. [redacted], RN, Clinical and Quality Review Specialist also appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for allergy shots from an out of network provider?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted]-year-old (DOB [redacted]) Medicaid beneficiary. (Exhibit A, p. 5 and testimony).

2. On [redacted], the MHP received a Prior Authorization Request from [redacted] at [redacted], an out of network provider, on behalf of the Appellant for weekly allergy shots. (Exhibit A, pp. 5-7).

3. On [redacted], denials were sent to the provider and the Appellant regarding a denial of the PA request for allergy shots from an out of network provider. (Exhibit A, p. 8-10).

4. On [redacted], the MHP received a written grievance on behalf of the Appellant requesting coverage for weekly allergy shots from [redacted] at [redacted] an out of network provider. (Exhibit A, pp. 11-14).

5. On [redacted] the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit 1).

6. On [redacted], a hearing was held with the MHP's Grievance Committee. (Exhibit A, p. 2, 16).

7. On [redacted], with the MHP's Grievance Committee sent the Appellant a denial letter indicating there were two network providers available and the MHP would provide transportation assistance to the network providers. (Exhibit A, pp. 19-22 and testimony).

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 MHPs.

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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, 1.022 Work and Deliverables, at §1.022 E (1) contract, 12/5/2013, pp. 22-23].

* * *

AA. Utilization Management

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
e) 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. 55].

Section 8 and 9 of the Appellant's Certificate of Coverage with the PHP FamilyCare plan provides the following exclusions and limitations from coverage:

SECTION 8. EXCLUSIONS FROM COVERAGE

The following is a list of exclusions from Your Coverage. We will not Cover any service, treatment, or supply listed in the exclusions, unless Coverage is required under applicable state or federal law.

* * *

(22) Non-Participating Providers. Services and supplies from a Non-Participating Provider. But this exclusion does not apply in the case of:

(a) Medical Emergency or when We have Certified the services and supplies in advance.

SECTION 9. LIMITATIONS

You may only receive services from a Participating Provider or another Health Professional. Your PCP must approve or authorize those services, and they must be Certified by Us in advance when required, unless this Certificate says otherwise. [Exhibit A, pp 19-20].

The Medicaid Provider Manual, Health Michigan Plan, July 1, 2014, provides the following:

1.2 BENEFIT ADMINISTRATION

All Healthy Michigan Plan beneficiaries, with the exception of some beneficiaries (e.g., Native Americans), are required to enroll in a health plan. Enrollees will select their health plan with assistance from MI Enrolls. In addition, behavioral health and substance use disorders will be administered in accordance with the current service delivery model.

1.2.A. MEDICAID HEALTH PLANS

MDCH contracts with Medicaid Health Plans (MHPs) to provide services to Medicaid beneficiaries. MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)

Although MHPs must provide the full range of covered services, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization (PA) requirements and utilization management and review criteria that differ from Medicaid requirements. [pp 1-2].

The Medicaid Provider Manual, Medicaid Health Plans, July 1, 2014, provides the following:

2.6 OUT-OF-NETWORK SERVICES

2.6.A. PROFESSIONAL SERVICES

With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services; and
- Tuberculosis services.

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. [p. 5].

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior authorization request under their contract with MDCH, the Appellant's Certificate of Coverage and the relevant provisions contained in the Medicaid Provider Manual. (Exhibit A, pp. 16-32).

Respondent MHP's witnesses established that the request for weekly allergy shots for the Appellant was for services from an out-of-network provider, [redacted] at [redacted]. The MHP witnesses 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 or in the event of an emergency. Accordingly, the MHP denied the Appellant's request for weekly allergy shots from an out-of-network provider. The MHP's witnesses established that the Appellant's weekly allergy shots could be done by [redacted] of [redacted] nearby network providers and the MHP would provide transportation assistance for the Appellant to their network provider for the requested services.

The Appellant's mother testified that she was not sure what is considered nearby, as the network providers where the MHP would have the Appellant go to for her weekly allergy shots are in [redacted] which is [redacted] miles away and [redacted] which is [redacted] miles away from [redacted] where the Appellant is going to school. She stated the Appellant is taking [redacted] credits and has play practice in the evenings, suggesting that the Appellant would not have time to make the round trip to a network provider for the allergy shots. She also alleged that it would cost [redacted] for the cab ride to [redacted] and [redacted] for a cab ride to [redacted] Appellant's

mother said the Appellant's doctor gives the Appellant the serum and the [redacted] at [redacted] gives her the shots. Appellant mother she understands that rules are rules, buts the MHP approved this arrangement last year.

In response the MHP witnesses advised that they granted an exception when it was represented to them last year that the Appellant would be off Medicaid when she turned [redacted] but now she is eligible for the new Healthy Michigan Plan.

The Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her PA request for weekly allergy shots from an out-of-network provider. The MHP has established that the requested service is a network only service, and that they will provide transportation to and from one of their network providers for the Appellant's weekly allergy shots. Accordingly, the MHP denial was proper.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for weekly allergy shots from an out-of-network provider was proper.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.