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. 2014-35854 QHP
Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted].

[redacted], Appeals Coordinator, PHI Air Medical, appeared and testified on Appellant's behalf. [redacted], PHI Director of Patient Financial Services; and [redacted], Medical Director, [redacted] appeared as witnesses for Appellant.

[redacted], Paralegal, represented [redacted], Michigan, the Medicaid Health Plan (MHP), Respondent. [redacted], Medical Directory of the MHP, appeared as a witness for the MHP.

ISSUES

(1) Does a provider acting on behalf of a Medicaid enrollee have a right to an administrative hearing on an issue dealing with the denial of payment for medical assistance?

(2) Did the MHP properly deny Appellant's request for reimbursement for emergency air transportation?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a[redacted]-year-old Medicaid beneficiary, born [redacted], who is

currently enrolled in the Respondent MHP. (Exhibit A)

2. On [redacted], when Appellant was [redacted] old, Appellant had an accidental ingestion of Risperdal, followed by seizure activity at home. Appellant was taken to [redacted] Emergency in [redacted]ills. Appellant exhibited more seizure activity in the emergency. Appellant was placed on a Keppra infusion, and Dr. S[redacted], requested rapid air transport to [redacted] for urgent pediatric neurology and PICU services, neither of which was available at the transferring hospital-[redacted].

3. [redacted], a Medicaid enrolled provider, provided air transportation for Appellant from [redacted], [redacted], to [redacted], MI. Emergency services were provided. (Exhibits A; I)

4. After a series of internal reviews and denials, the MHP denied payment to the provider. On [redacted] the provider filed a request for an administrative hearing with the Michigan Administrative Hearing System with signed authorization from the member authorizing [redacted]-the provider-to act as an authorized hearing representative. (Exhibit 1.24)

5. The air transport service was provided to the member. The member is not being charged by [redacted]; federal and state law prohibits a Medicaid enrollee from billing a enrollees for Medicaid covered benefits. The MHP denied payment to [redacted].

6. Exhibit I.22 states that the denial was due to services being deemed not medically necessary. (Exhibit 1.22; Testimony)

7. On [redacted], the provider requested a Level 1 review of Respondent MHP's determination. (Exhibit 1.22-23) On [redacted], the MHP upheld the original denial, finding that the air transport was not medically necessary; that the member was transferred by air in 10 minutes with ground time of 20 minutes; that a ground transport is the most effective and least costly transportation. (Exhibit 1.21)

8. Evidence shows that the expected air time was 4-10 minutes; expected ground transport 27 minutes. (Exhibits A.5; I.17)

9. On [redacted], the provider requested a Level 2 review of Respondent MHP's determination, in which it argued that prior authorization is not required for emergency transportation; that the air transportation was medically necessary due to Appellant exhibiting a second seizure at [redacted]; and that the air transport flight crew possess advanced skill levels including pediatric critical care services necessary

due to a potential of further deterioration en-route that would require interventions or medications beyond the scope of local ground ambulance crews. (Exhibit 1.19) Appellant's Level 2 request stated that the Appellant was receiving a Keppra infusion en-route which is outside the scope of standard ALS ground units; that there was concern for the need for pharmacological assisted intubation due to apnea that is beyond the scope of practice of local ground EMS agencies. (Exhibit I.17; Exhibit I.2)

10. On [redacted], the MHP again upheld the original denial, finding that a ground ambulance would not endanger the enrollee's life or health. (Exhibit I.14-16).

11. On [redacted], Appellant's Request for Hearing was received by the Michigan Administrative Hearing System, with a subsequent Request for Hearing Letter. (Exhibit 2.3)

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.

ISSUE (1)

The MHP motioned to deny jurisdiction for this administrative hearing on the grounds that the provider does not have a right to an administrative hearing under federal and state law. As noted in the Findings of Fact, the provider is not, in fact, requesting an administrative hearing. Rather, the member completed the hearing request, and, named the provider as an authorized hearing representative.

42 CFR Part 431 contains rights for a fair hearing:

§431.220 When a hearing is required.

(a) The State agency must grant an opportunity for a hearing to the following:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.

(2) Any beneficiary who requests it because he or she believes the agency has taken an action erroneously.

(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged.

(4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.

(5) Any MCO or PIHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.

(6) Any PAHP enrollee who has an action as stated in this subpart.

(7) Any enrollee who is entitled to a hearing under subpart B of part 438 of this chapter.

(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

As noted in 42 CFR 431.220, further reference must be made to subpart B part 43. CFR 42 438.400 states in part:

§438.400 Statutory basis and definitions.

(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the State;

(5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or

(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as "action" is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.) 42 CFR 438.400

As noted above, 43 CFR 431.220(5) states that a hearing is required whenever any MCO or PIHP enrollee is entitled to a hearing under subpart F of part 435. Under subpart F, or 42 CFR 438.400(a)(1) and (a)(3), any person is entitled to a fair hearing whose claim for assistance is denied or not acted upon promptly (438.400(1)), and, Medicaid enrollees or providers acting on their behalf challenge the payment for medical assistance (438.400(a)(3)). Moreover, under the definitions, an action means: "The denial, in whole or in part, of payment for a service." 42 CFR 438.400(b)(3).

42 CFR 438.400 states that a provider, representing a member, may challenge payment for a service. Respondent is correct-this case deals with a payment issue. But the Respondent is not correct that the member cannot authorize the provider to act as a representative in a dispute regarding a denial of payment for a service. It is clear from the explanation of the term "grievance" in 42 CFR 438.400 that an 'action' handled by an MCO or PIHP must allow access to the State fair hearing process. The 'fair hearing process' is a legal description of the right to an administrative hearing under the rights and definitions found at 42 CFR 431.220.

Thus, this Administrative Law Judge (ALJ) jurisdiction is proper pursuant to 42 CFR 431.200 and 431.400.

ISSUE (2)

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.

- 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 DCH-MHP contract provisions require that all services provided be medically necessary. With regard to prior authorization, the Midwest Health Plan Administrative Manual provides, in pertinent part:

Per the terms of the Plan contract with the Michigan Department of Community Health, Members may access any of the following services directly, without prior authorization or referral from the PCP or MHP:

- Emergency Room Services – Facility and Professional Components

* * * *

- Emergency Transportation

* * * *

The Michigan Medicaid Provider Manual provides, with regard to Ambulance services, in pertinent part:

1.1 GENERAL INFORMATION

This chapter applies to Ambulance providers and Hospital-Owned Ambulance Services.

The Michigan Department of Community Health (MDCH), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate when:

- Medical/surgical or psychiatric emergencies exist; and/or
- No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Services that have been excluded from direct reimbursement to ambulance providers are:

- Services that are not medically necessary.

1.2 COMMON TERMS

The following terms have specific meanings in the Ambulance Program:

Emergency Medical Condition

An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

1.4 MEDICAL NECESSITY

The medical care personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and Medicaid guidelines. Medical necessity for

nonemergency transports must be substantiated with a physician's written order. Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file.

2.1 AIR AMBULANCE

MDCH reimburses air ambulance providers who are licensed by the State of Michigan and properly enrolled with MDCH. Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or helicopter air ambulance status.

2.1.B. HELICOPTER AIR AMBULANCE

Helicopter air ambulance providers must submit a copy of their license with their enrollment application. The Medicaid Provider Enrollment file reflects enrollment as a helicopter air ambulance provider.

MDCH covers helicopter air ambulance services only under the following circumstances:

- Time and distance in a ground ambulance would be a hazard to the life of the patient.
- Necessary care and services for the beneficiary's needs are not available at the local hospital.
- Transport is for medical or surgical procedures only and not for diagnostic purposes.

(Refer to the Ambulance Services subsection of this chapter for documentation requirements for emergency and medically necessary services.)

Coverage of helicopter air ambulance services includes the helicopter base rate, mileage, and waiting time:

- **Base Rate:** Reimbursement for the helicopter air ambulance base rate includes oxygen, equipment and supplies essential for the provision of services, and accompanying personnel.
- **Mileage:** Mileage may only be billed for loaded air miles.
- **Waiting Time:** Waiting time which exceeds 30 minutes is reimbursable as detailed in the Waiting Time subsection of this section.

Ambulance Chapter
October 1, 2013, pp 1-6

Here, it would appear from the above policy that Appellant's representatives are correct that prior authorization would not be required for the air transport at issue here because the MHP's own policy indicates that prior authorization is not required for "Emergency Transportation". It is reasonable to conclude that "Emergency Transportation" would include the air transport at issue here. The only question is whether it was medically necessary to transport Appellant via air.

There does not seem to be any dispute between the parties herein that Appellant's transfer was needed-Appellant needed a neuro assessment, and, Appellant needed the services that a PICU offers, neither of which were available from the transferring hospital. The sole substantive issue is the means-air transport or ground.

In its denial notice, the MHP indicated that Appellant did not meet the criteria for air transport because the medical necessity criterion for air transport was not met. The MHP's denial letter of [redacted] states that medical necessity was not met as Appellant's condition would not be endangered by the use of ground ambulance because of the lack of 'serious jeopardy,' or serious impairment of bodily functions or serious dysfunction of any bodily organ or part." (Exhibit I.14-15) In other words, Appellant was evidentially considered stable from the MHP's position.

Appellant's representative testified that Appellant needed to be transferred by air transport based on the ordering physician because Appellant was on a Keppra infusion and would be en-route, and, because of the potential for apnea and pharmacological assisted intubation might be necessary-both of which are beyond the scope of local ground ambulance. (Exhibit 2.3) Appellant's representative further argued that personnel in ground transport are not skilled in these critical practices needed by the Appellant.

In support of its position, the MHP offered a letter from [redacted] dated 1[redacted] from [redacted], Director of the PICU and [redacted], Medical Director of the PICU that attests to the scope of practice of ground transport personnel. This letter states that EMS providers, including advanced ground EMS providers, are not currently required by state license ground providers to have any critical care training and only 3 to 4 hours of pediatric training continuing every 3 years for license renewal. More importantly, air medical transportation personal have 2 advanced providers at all times, hundreds of hours of continuing education, most of which is in the critical care environment, including intubation, issues with invasive lines with pediatric populations, which is out of the scope of most ground EMS providers. In addition, EMS providers are not generally trained to do pharmacological interventions that can be accomplished by air transport personnel, even if the medications are in the ambulance.

At the administrative hearing, [redacted], the MHP's medical director, testified that

that there was nothing special about a Keppra infusion that a grounds transport could not handle. Moreover, [redacted] testified that "one alternative" that could have been taken by the hospital would be for the transferring hospital to call around to different ground transport services to inquire if they offered the services that Appellant's physician deemed necessary via air transport.

The facts here indicate that there was an emergency situation-the Appellant had seizure activity before arriving at the hospital, and, seizure activity at the hospital. Appellant was [redacted] old, had a Keppra infusion, and the potential for pharmacological assisted intubation due to apnea which is beyond the scope of local ground ambulance crews. There was no evidence that Appellant's physicians considered Appellant stable. He had not been in the emergency facility for an extended period of time. Even the MHP's physician seemed to agree that the training of the local ground ER transport would not normally meet training and scope of the emergency herein by his response that 'calling around' would be an alternative. This ALJ finds that under these facts, Appellant meets the medical necessity as it is defined under the Medicaid policy and law. The fact that the air transport apparently did not require the emergency procedures, after-the-fact is not a criteria for an emergency assessment under the medical necessity criteria. At the time that the decision had to be made, air transport would take 4-10 minutes; by ground 22-30. Appellant was having seizures; the Keppra infusion combined with potential for pharmacological intubation on an [redacted] old meets criteria established in the MPM 2.1.B.

The MHP's determination is reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

Issue 1) Jurisdiction is proper for the reasons set forth herein, and

Issue 2) the MHP did not properly deny Appellant's request for emergency air transportation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

\s_____
Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director

Michigan Department of Community Health

cc: [redacted]

JS[redacted]

Date Signed: [redacted]

Date Mailed: [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.