



**Docket No. 14-006457 MHP**  
**Decision and Order**

5. However, Appellant's mother preferred that Appellant be seen by a hematologist at the [REDACTED], a non-participating provider, because the doctors there were familiar with Appellant's case. (Testimony of Appellant's representative).
6. On or about [REDACTED], the MHP received a prior authorization request submitted on Appellant's behalf and requesting that she see a pediatric hematologist at the [REDACTED] on [REDACTED] for a consultation prior to a tonsillectomy. (Testimony of [REDACTED]).
7. The next day, the MHP denied that request on the basis that the requested provider is not a participating provider in the MPH's network and the accepted standard of care is available within the MPH's network of providers. (Testimony of Appellant's representative; Testimony of [REDACTED]).
8. The MHP also directed Appellant to see the provider who participates in the plan on [REDACTED]. (Testimony of Appellant's representative; Testimony of [REDACTED]).
9. On or about [REDACTED], the MHP received a second prior authorization request submitted on Appellant's behalf and requesting that she see a pediatric hematologist at the [REDACTED] for a consultation prior to a tonsillectomy. (Testimony of [REDACTED]).
10. The request was the same as the previous one and, after a physician review, it was also denied in a written notice sent out [REDACTED]. (Testimony of [REDACTED]).
11. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf in this case. (Respondent's Exhibit A, page 4).
12. On [REDACTED], while the appeal was pending, Appellant had a consultation with the pediatric hematologist at the [REDACTED] [REDACTED] (Testimony of Appellant's representative; Testimony of [REDACTED]).
13. The visit was paid for by Appellant's father's private insurance. (Testimony of Appellant's representative; Testimony of [REDACTED]).
14. Appellant's representative now seeks to have the MHP reimburse Appellant and Appellant's representative for travel and lodging costs related to that hematology consultation. (Testimony of Appellant's representative; Testimony of [REDACTED]).

**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 and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

*MPM, April 1, 2014 version  
Medicaid Health Plan Chapter, page 1 (emphasis added)*

Both the MPM and the MHP's Utilization Management and Review Criteria identify circumstances where an enrollee could receive services through an out-of-network provider:

## **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.

*MPM, April 1, 2014 version  
Medicaid Health Plans Chapter, page 5*

### **UPHP/CSHCS/ABW/MICChild Utilization Management Out-of-Plan Referral Authorization Criteria**

\* \* \*

UPHP uses an integrated approach to coordinate and promote optimal utilization of health care resources; and make utilization decisions that affect the health care of members in a fair, impartial, and consistent manner.

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UPHP requires that services be provided within the UPHP network (in-plan) when available. *Services must be medically necessary and appropriate, and conform to professionally accepted standards of care.*

\* \* \*

Criteria for authorizing out-of-plan services are as follows:

1. The request is initiated by the primary care physician, an in-plan specialist, or an out-of-plan specialist with a valid authorization.
2. It is verified that the requested services:
  - a) are not available in-plan, or
  - b) cannot reasonably be provided in-plan in a timely manner (timely = within 30 days of an acute non-urgent condition), or
  - c) are referred by an in-plan specialist to a higher level facility due to complexity of a case, or
  - d) eliminate lengthy travel to an in-plan provider that would exacerbate a chronic condition

*Respondent's Exhibit A, page 7*

However, none of those situations apply in this case. Appellant's mother acknowledges that she only made the prior authorization request because she preferred that Appellant be seen by a hematologist at the [REDACTED], a non-participating provider. Moreover, while her preference was based on the fact that the doctors there were familiar with Appellant's case, she also acknowledged that there was no medical necessity at that time in seeing the non-participating provider and that the MHP had in-plan specialists available to see Appellant in a timely manner.

Appellant's preference for a specific provider is insufficient to justify out-of-network services and the MHP has provided sufficient evidence demonstrating both that it had providers within its network available to Appellant and that there was no medical necessity to go to an out-of network provider. Accordingly, the MHP's decision must be affirmed.

[REDACTED]  
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**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 a hematology consultation with a non-participating provider.

**IT IS THEREFORE ORDERED** that:

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

*Steven Kibit*

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Steven Kibit  
Administrative Law Judge  
for Nick Lyon, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

**\*\*\* 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.