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. 14-009202 MHP

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

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted], Supervisor of Appeals and Grievances, represented [redacted], the Respondent Medicaid Health Plan (MHP). [redacted], a Medical Director at the MHP, testified as a witness for Respondent.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for referral to an out-of-state 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. Appellant is a [redacted]-year-old female enrolled in the Respondent MHP and also receiving services through the Children's Special Health Care Services (CSHCS) program. (Respondent's Exhibit A, pages 5-6; Testimony of [redacted]).

2. On or about [redacted], the MHP received a prior authorization request submitted on behalf of Appellant by a [redacted] and requesting a referral for treatment by a [redacted], a pediatric immunologist located in [redacted]. (Respondent's Exhibit A, pages 5-12).

[1] For purposes of hearing, Appellant's case was consolidated at the request of the parties with two other cases involving Appellant's siblings.

3. That prior authorization request indicated Appellant has been diagnosed with a P1-3 Kinases Mutation Immunodeficiency. (Respondent's Exhibit A, page 5).

4. The medical documentation submitted along with the request also indicated that the diagnosis had been made by [redacted] after Appellant was referred to him in [redacted] for treatment of recurrent infections and immunoglobulin replacement. (Respondent's Exhibit A, pages 6-12).

5. The medical documentation submitted along with the request further indicated that [redacted] has developed a plan for treatment of Appellant's condition. (Respondent's Exhibit A, page 11).

6. On [redacted], the MHP sent [redacted] written notice that the prior authorization request was denied. (Respondent's Exhibit A, pages 13-16).

7. With respect to the reason for the denial, the notice stated:

> The Michigan Department of Community Health Medicaid Provider Manual – SECTION 10 – OUT-OF-STATE MEDICAL CARE requires documentation showing: 1) request for out-of-state referral is submitted by the appropriate, CSHCS authorized in-state subspecialist with whom the client will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state; 2) the in-state subspecialist and the out-of-state specialist maintain a collaborative (work together) relationship with regard to determining, coordinating, and providing the client's medical care, including a plan to transition the client back to in-state services as appropriate, 3) comparable care (the term "comparable care" does not require that services be identical) for the CSHCS (Children's Special Health Care Services) qualifying diagnosis (medical condition) cannot be provided within the [redacted]. There is no documentation from [redacted] at [redacted] that she is not capable of caring for this member's condition

> due to a lack of expertise. There is no documentation showing: 1) request for out-of-state referral is submitted by the appropriate, CSHCS authorized in-state subspecialist with whom the client will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state; 2) the in-state subspecialist and the out-of-state specialist maintain a collaborative (work together) relationship with regard to determining, coordinating, and providing the client's medical care, including a plan to transition the client back to in-state services as appropriate, 3) comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis (medical condition) cannot be provided within the [redacted] to meet criteria guidelines.
>
> *Respondent's Exhibit A, page 13*

8. In a letter dated [redacted] described how Appellant was referred to him after a [redacted] could not diagnose Appellant's condition; how [redacted] and his office did diagnose Appellant; why the optimal treatment for Appellant is rapidly evolving and requires experts; and how [redacted] and his office are experts that can treat Appellant. (Respondent's Exhibit A, pages 3-4).

9. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on behalf of the minor Appellant in this matter. (Petitioner's Exhibit 1, pages 1-4).

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.

In 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 by ALJ)*

Here, in addition to being enrolled in the MHP, Appellant is also receiving services through the Children's Special Health Care Services (CSHCS) program:

> Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Community Health (MDCH) created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the

> federal government under Title V of the Social Security Act and the annual MDCH Appropriations Act. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent.
>
> MDCH covers medically necessary services related to the CSHCS qualifying condition for individuals who are enrolled in the CSHCS Program. Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of nonmedical program criteria.
>
> An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefits Waiver (ABW), Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and for the other applicable program(s).
>
> *MPM, April 1, 2014 version*
> *Children's Special Health Care Services Chapter, page 1*

Moreover, with respect to CSHCS and out-of-state providers, the MPM states:

> **SECTION 10 – OUT-OF-STATE MEDICAL CARE**
>
> CSHCS covers out-of-state **emergency** medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
>
> - Serious jeopardy to the health of the client;
> - Serious impairment to bodily functions; or
> - Serious dysfunction of any bodily organ or part.
>
> Non-emergency medical care related to the qualifying diagnosis is defined as not meeting the definition of

emergency medical care stated above. Out-of-state non-emergency medical care is covered only when the service has been prior authorized by MDCH. Prior authorization requests for out-of-state services may be approved when all of the following criteria are met:

- The requested service is related to the CSHCS qualifying diagnosis;
- The request for out-of-state referral is submitted by the appropriate, CSHCS-authorized in-state subspecialist with whom the client will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state;
- The in-state subspecialist and the out-of-state specialist maintain a collaborative relationship with regard to determining, coordinating, and providing the client's medical care, including a plan to transition the client back to in-state services as appropriate;
- Comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis cannot be provided within the State of Michigan;
- The requested service is accepted within the context of current medical standards of care as determined by MDCH;
- The service has been determined medically necessary by MDCH because the client's health would be endangered if he were required to travel back to Michigan for services, if applicable.

All out-of-state providers must complete the Community Health Automated Medicaid Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to MDCH.

> Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDCH. (Refer to the General Information for Providers Chapter of this manual for additional information.)
>
> The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state. Refer to the Travel Assistance section of this chapter for specific information.
>
> *MPM, April 1, 2014 version*
> *Children's Special Health Care Services Chapter, page 19*

In this case, the MHP denied a prior authorization request for referral to [redacted] an out-of-state provider, pursuant to the above policy. As described in the notice of denial and testified to by [redacted], the request and documentation submitted in this case failed to demonstrate that Appellant met all of the criteria for out-of-state non-emergency medical care. In particular, [redacted] noted that there was no evidence that comparable care was not available in [redacted] and Appellant has actually been seen by a pediatric immunologist in [redacted].

Appellant's representative bears the burden of proving by a preponderance of the evidence that the MHP erred in denying the prior authorization request. Moreover, in reviewing the MHP's decision, the undersigned Administrative Law Judge is limited to reviewing the decision in light of the information available at the time the decision was made.

Here, given the contents of the prior authorization request and the medical documentation attached to that request, Appellant's representative has failed to meet her burden of proving that the MHP erred. The request and documentation describe Appellant's diagnosis, how Appellant was diagnosed in [redacted] by [redacted] and the plan for treatment in [redacted]. However, there is no discussion or indication as to why the requested service must be provided out-of-state; how the in-state subspecialist will maintain a collaborative relationship with the out-of-state provider, including a plan to transition the client back to in-state services as appropriate; or why comparable care is not available in the [redacted]. Without such documentation, the MHP cannot approve the out-of-state services and, consequently, it properly denied the prior authorization request in this case.

To the extent Appellant's representative has additional or updated information regarding Appellant's medical condition or the need for out-of-state treatment of that condition,

she is free to have the doctor resubmit the request for a referral, along with all the relevant documents and information. With respect to the decision at issue in this case, however, the MHP's actions must be affirmed given the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's prior authorization request for referral to an out-of-state provider.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

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.