

**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:**

Docket No. 2014-2360 QHP

██████████

██████████

██████████

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 the Appellant's request for a hearing.

After due notice, a telephone hearing was held ██████████  
appeared and testified. ██████████, Appeals Coordinator, represented  
██████████, the Medicaid Health Plan (MHP). ██████████  
██████████, Medical Director, appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny Appellant's request to see an out-of-network provider for services?

**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 who is currently enrolled in the Respondent MHP.
2. On or about ██████████ the MHP received Appellant's Prior Authorization request to see an out-of-network cardiologist for services. (Exhibit A, p. 67).
3. On ██████████ the MHP sent a denial notice to the Appellant, stating: "...The requested service is denied because the service may be obtained by a ██████████ network provider.

There is no documentation showing the services cannot be provided by a network provider.” (Exhibit A, p. 72).

4. On ██████████ Appellant’s Request for Hearing, protesting the denial, was received by the Michigan Administrative Hearing System.

### **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 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 aforementioned contract between the Department and the MHP states that the MHP must "operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations." The contract allows an MHP to make an out-of-network referral if it is medically necessary, for example, if the MHP did not have a cardiologist in its network that was able to provide Appellant with the medical treatment that he needs. (See Article II-H (2), Utilization Management, September 30, 2004) Appendix A 26 of the MHP's certificate of

coverage also allows for out-of-network referrals if the services are medically necessary, and there is no in-network provider. Additionally, the Medicaid provider manual contains many provisions where prior authorization is mandatory for certain services. The MHP's certificate of coverage clearly and unambiguously states:

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, inside or outside of the State of Michigan, on a timely basis. (Appendix A 26)

The Michigan Department of Community Health (MDCH) Medicaid Provider Manual, section 1.9 (Prior Authorization), states:

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility.

*Medicaid Provider Manual, Practitioner Section,  
Effective July 2013.*

In this case, Appellant requested a hearing, protesting the denial of the prior authorization request to see an out-of-network cardiologist. Appellant testified that the cardiologist that he wants to see is the cardiologist who performed surgery on him and is familiar with his medical history.

The MHP established that it properly denied Appellant's request for medical services provided by an out-of-network provider. The preponderance of evidence fails to establish that the medical services or specific medical treatment that Appellant is requesting cannot be provided by a ██████████ participating provider. ██████████ testified on behalf of the MHP and stated that there are several hundred participating cardiologist who can handle Appellant's medical needs; and the training, practice history, and quality of care delivered by the MHP's participating providers have been verified. Appellant testified that he has been having problems finding a cardiologist who participates with the MHP. ██████████ responded by stating that the MHP can assist Appellant in finding a participating cardiologist.

### **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 to see an out-of-network provider.

