

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. 2014-35563 QHP

██████████

██████████ . ██████████

Appellant.

_____ /

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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Appeals Coordinator, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████, a Medical Director at the MHP, testified as a witness for Respondent.

ISSUE

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

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 Medicaid beneficiary previously enrolled in the Respondent MHP.
2. In ██████████, the MHP received a prior authorization request submitted on Appellant's behalf by a ██████████ and requesting that Appellant be approved for office visits with ██████████.
3. At that time, ██████████ was not an enrolled provider with the MHP.
4. The MHP also had over thirty medical providers within ██████████ of ██████████ office that were enrolled with the MHP and that could provide the routine medical services requested.

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5. The MHP therefore sent Appellant written notice stating that the request for out-of-network provider services was denied on the basis that the services could be obtained through a [REDACTED] network provider.
6. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received a complete and signed request for hearing filed by Appellant.

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 . . .

*MPM, January 1, 2014 version
Medicaid Health Plan Chapter, page 1*

Both the MPM and the MHP's Contract with the Department also 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*

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(2) Out-of-Network Services

The Contractor must reimburse out-of-network providers for covered services if the service was medically necessary, authorized by the Contractor, and could not reasonably be obtained by a network provider, inside or outside the State of Michigan, on a timely basis. Covered services are considered authorized if the Contractor does not respond to a request for authorization within 24 hours of the request (authorization for emergent services is covered under Section 1.022(F)(1)(c)). This provision applies to out-of-network providers inside and outside the State of Michigan.

The Contractor must comply with Medicaid Policy regarding requirements for authorization and reimbursement for out-of-network providers. Out-of-network claims must be paid at established Medicaid fees in effect on the date of service for paying participating Medicaid providers as established by Medicaid Policy. If Michigan Medicaid has not established a specific rate for the covered service, the Contractor must follow Medicaid Policy for the determination of the correct payment amount.

Contract No. 071B02000, FY2013, page 26

However, none of those situations apply in this case. Appellant was merely seeking routine medical treatment and those services could reasonably be obtained through an in-network provider on a timely basis. 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 multiple providers within its network available to Appellant and that medical necessity to go to an out-of network provider had not been established.

In response, Appellant testified that she was directed to a particular doctor's office, which included [REDACTED], by the MHP in [REDACTED] and that she has continually been receiving services through him since that time. She also testified that it was only after [REDACTED] moved offices and informed her that he had never been paid that they initiated the prior authorization request and appeal. She also testified that she feels bad that [REDACTED] never got paid.

Nevertheless, whatever billing issues [REDACTED] has with the doctors he previously worked with or with the MHP, those issues are not before the undersigned Administrative Law Judge.

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With respect to the issue that is in dispute in this case, *i.e.* the denial of out-of-network services, the evidence demonstrates that, at the time of the prior authorization request, [REDACTED] was not a network provider and there was no medical necessity for out-of-network services. Accordingly, the MHP's decision must be affirmed.

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 request to see an out-of-network provider.

IT IS THEREFORE ORDERED that:

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



Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.