

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. 2014-35753 MCE

██████████

██████████

██████████

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 Petitioner's request for hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Medical Exception and Special Disenrollment Program Specialist, appeared and testified on behalf of the Michigan Department of Community Health ("MDCH" or "Department").

ISSUE

Did the CMH properly deny Appellant's requests for medical exceptions from mandatory Managed Care Program enrollment?

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 was approved for the Healthy Michigan Plan on ██████████ and is in the mandatory population for enrollment into a Healthy Michigan Program Medicaid Health Plan. (Testimony of ██████████).
2. On ██████████, Appellant enrolled in ██████████ (██████████"). (Testimony of ██████████).
3. On or about ██████████, the Department received a managed care exception request from Appellant and a ██████████. (Respondent's Exhibit A, page 30).
4. In that request, ██████████ indicated that she had been treating Appellant for discoid lupus since ██████████ and had been seeing Appellant monthly. (Respondent's Exhibit A, page 30).

Docket No. 2014-35753 MCE
Decision and Order

5. [REDACTED] also checked “no” in the section of the form asking her if she worked with any of the Medicaid Health Plans or County Health Plans. (Respondent’s Exhibit A, page 30).
6. On or about [REDACTED], the Department received a managed care exception request from Appellant and a [REDACTED] [REDACTED]. (Respondent’s Exhibit A, page 29).
7. In that request, [REDACTED] indicated that he had been treating Appellant for asthma since [REDACTED] and that visits would be required every [REDACTED] months. (Respondent’s Exhibit A, page 29).
8. [REDACTED] also checked “yes” and wrote “All plans” in the section of the form asking him if he worked with any of the Medicaid Health Plans or County Health Plans. (Respondent’s Exhibit A, page 29).
9. On or about [REDACTED], the Department received a managed care exception request from Appellant and a [REDACTED]. (Respondent’s Exhibit A, pages 10-11).
10. In that request, [REDACTED] indicated that he had started treating Appellant for an overactive bladder on [REDACTED], with only one visit having been completed. (Respondent’s Exhibit A, page 10).
11. [REDACTED] also left blank the section of the form asking him if he worked with any of the Medicaid Health Plans or County Health Plans. (Respondent’s Exhibit A, page 10).
12. On or about [REDACTED], the Department received a managed care exception request from Appellant and a [REDACTED]. (Respondent’s Exhibit A, page 12).
13. In that request, [REDACTED] indicated that she had been treating Appellant for allergies since [REDACTED] and that there would have to be [REDACTED] to [REDACTED] visits per year. (Respondent’s Exhibit A, page 12).
14. [REDACTED] also checked “yes” in the section of the form asking her if she worked with any of the Medicaid Health Plans or County Health Plans. (Respondent’s Exhibit A, page 12).
15. On or about [REDACTED], the Department received a managed care exception request from Appellant and a [REDACTED]. (Respondent’s Exhibit A, pages 13-17).
16. In that request, [REDACTED] indicated that she had treated Appellant for plantar fasciitis on [REDACTED], but no more visits would be necessary. (Respondent’s Exhibit A, page 13).

██████████
Docket No. 2014-35753 MCE
Decision and Order

17. ██████████ also left blank the section of the form asking him if she worked with any of the Medicaid Health Plans or County Health Plans. (Respondent's Exhibit A, page 13).
18. On or about ██████████, the Department received a managed care exception request from Appellant and a ██████████ (Respondent's Exhibit A, pages 20-28).
19. In that request, ██████████ indicated that he had been treating Appellant since ██████████ and was seeing Appellant quarterly. (Respondent's Exhibit A, page 20).
20. ██████████ also checked "yes" in the section of the form asking him if he worked with any of the Medicaid Health Plans or County Health Plans and he provided a list of such plans, which included ██████████. (Respondent's Exhibit A, pages 20-21).
21. After the Department received the requests for medical exception, ██████████ checked the Department's provider file database and confirmed that ██████████, and ██████████ participate with Appellant's Medicaid Health Plan. (Respondent's Exhibit A, pages 32-38; Testimony of ██████████).
22. ██████████ also telephoned ██████████ office and confirmed that the office is continuing to accept and bill Appellant through Appellant's Medicaid Health Plan. (Testimony of ██████████).
23. On ██████████, the Department sent Appellant written notice that her request for a medical exception to remain in the Fee-For-Service (FFS) Medicaid setting due to ongoing treatment with ██████████ or ██████████ was denied. (Respondent's Exhibit A, pages 8-9).
24. Specifically, that denial notice stated in part:

Your request for Medical Exception from managed care enrollment has been denied for the reason(s) listed below:

- Our records show that ██████████ & ██████████ & ██████████ & ██████████ all work with or accept referrals from health plans that are available for you to enroll in. The specialists at ██████████ work with ██████████ and ██████████ and also accept referrals from several other health plans

Docket No. 2014-35753 MCE
Decision and Order

including [REDACTED].

- The information from your doctors described the standard treatment of ongoing chronic medical conditions; they did not describe the active treatment or frequency of visits that would allow for a time limited medical exception.

Our records show that you have been enrolled in [REDACTED] since [REDACTED]. [REDACTED] should be able to provide or arrange for the health care services necessary to treat the medical conditions listed in your request, including specialty care. You can ask the health plan for a case manager that will work with you or your doctors to help you set up your specialty care.

Respondent's Exhibit A, page 8

25. On [REDACTED], the Department sent Appellant written notice that her request for a medical exception to remain in the Fee-For-Service (FFS) Medicaid setting due to ongoing treatment with [REDACTED] or [REDACTED] was denied. (Respondent's Exhibit A, pages 18-19).
26. Specifically, that denial notice stated in part:

Your request for Medical Exception from managed care enrollment has been denied for the reason(s) listed below:

- Our records show that [REDACTED] and [REDACTED] either work with or accept referrals from health plans that are available for you to enroll in. The specialists at [REDACTED] work with [REDACTED] and [REDACTED] and also accept referrals from several other health plans including [REDACTED]. Per telephone contact with [REDACTED] office on [REDACTED] they also accept out of network referrals from [REDACTED] [REDACTED] for office visits. [REDACTED] is

Docket No. 2014-35753 MCE
Decision and Order

listed as a primary care provider for several health plans including [REDACTED] and [REDACTED]

- The information from your doctors described the standard treatment of ongoing chronic medical conditions; they did not describe the active treatment or frequency of visits that would allow for a time limited medical exception.

Our records show that you have been enrolled in [REDACTED] since [REDACTED] should be able to provide or arrange for the health care services necessary to treat the medical conditions listed in your request, including specialty care. You can ask the health plan for a case manager that will work with you or your doctors to help you set up your specialty care.

Respondent's Exhibit A, page 18

27. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Respondent's Exhibit A, page 6).
28. In that request, Appellant states that [REDACTED] has diagnosed her with lupus; [REDACTED] only accepts straight Medicaid; and Appellant would like to continue her treatment plan with [REDACTED]. (Respondent's Exhibit A, page 6).
29. Following the receipt of the request for hearing, [REDACTED], the Department's Chief Medical Director, reviewed and upheld the denials of the requests for medical exceptions. (Respondent's Exhibit A, page 31).

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.

Docket No. 2014-35753 MCE
Decision and Order

On May 30, 1997, the Department was notified of the Health Care Financing Administration's approval of its request for a waiver of certain portions of the Social Security Act to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Qualified Health Plans.

Michigan Public Act 154 of 2006 states, in relevant part:

Sec. 1650 (3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to managed care enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

Similarly, the Michigan Medicaid Provider Manual (MPM) states in the applicable part:

9.3 MEDICAL EXCEPTIONS TO MANDATORY ENROLLMENT

The intent of a medical exception is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (M.D. or D.O.) who would not be available to the beneficiary if the beneficiary was enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is available only to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs: (Underline added).

- The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- The condition stabilizes and becomes chronic in nature, or
- The physician becomes available to the beneficiary through enrollment in a MHP, whichever occurs first.

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

9.3.A. DEFINITIONS

Serious Medical Condition	Grave, complex, or life threatening. Manifests symptoms needing timely intervention to prevent complications or permanent impairment. An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.
Chronic Medical Condition	Relatively stable. Requires long term management. Carries little immediate risk to health. Fluctuates over time, but responds to well-known standard medical treatment protocols.
Active Treatment	Active treatment is reviewed in regards to

**Docket No. 2014-35753 MCE
Decision and Order**

	<p>intensity of services when:</p> <ul style="list-style-type: none">▪ The beneficiary is seen regularly, (e.g., monthly or more frequently), and▪ The condition requires timely and ongoing assessment because of the severity of symptoms and/or the treatment.
Attending/Treating Physician	<p>The physician (MD or DO) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.</p>
MHP Participating Physician	<p>A physician is considering participating in a MHP if he is in the MHP provider network or is available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with a MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan</p>

	and no medical exception would be allowed.
--	--

9.3.B. PROCESS FOR REQUESTING A MEDICAL EXCEPTION

The Medicaid beneficiary must initiate the review process for medical exception by completing Section I of the Medical Exception Request (form MSA-1628). Beneficiaries can obtain forms, discuss managed care options, or ask questions regarding the medical exception process by contacting MI Enrolls. (Refer to the Directory Appendix for contact information.) If the beneficiary has been enrolled in a MHP for more than two months, the medical exception request does not apply.

9.3.C. PHYSICIAN RESPONSIBILITY

The physician who is actively treating the beneficiary for the serious medical condition must complete Section II of the MSA-1628. If multiple physicians are involved, each one must complete a separate form. The physician completing the form must be actively treating the beneficiary, and must not be participating with or have any arrangement with a MHP with which the beneficiary can be enrolled. The information provided by the physician must include:

- A detailed description of the serious medical condition that is being treated, including the diagnosis and current active signs and symptoms in adequate detail to justify the degree of seriousness. Diagnosis alone is not sufficient.
- The length of time that the beneficiary has been actively treated for this condition by the physician completing the form.
- The treatment plan in place, including any planned interventions and a list of all current and anticipated medications.
- The frequency of visits.

██████████
Docket No. 2014-35753 MCE
Decision and Order

- The anticipated length of time (in months) that the beneficiary will need this treatment.

A Medical Exception Request cannot be processed without all of the above information. MDCH will verify that the treating physician is not available in any MHP in which the beneficiary can be enrolled. If an exception to managed care enrollment is granted, the MDCH will identify a period of time, up to one year, for which it is approved. At the end of that period, the beneficiary will be eligible for enrollment in a MHP.

MPM, April 1, 2014 version
Beneficiary Eligibility Chapter, pages 43-45

Here, Appellant submitted six requests for medical exception within two months of being enrolled in a Medicaid Health Plan. Each request was denied and Appellant now bears the burden of proving by a preponderance of the evidence that the Department erred in denying her requests.

With respect to five of the requests, Appellant clearly failed to meet that burden of proof as the undisputed record in this case demonstrates that ██████████, ██████, and ██████ participate with Appellant's Medicaid Health Plan and are not providing Appellant with any frequent, active treatment.

██████████, on the other hand, at least sees Appellant monthly and could be deemed to be providing active treatment. However, Appellant stills fails to demonstrate that she is treating Appellant for a serious medical condition and would not be available to the Appellant if the Appellant was enrolled in a MHP. For example, while ██████ ██████████ indicated on the exception request form that she does not participate with any Medicaid Health Plans, Miller credibly testified that ██████████ office later verbally indicated that it would continue to accept and bill Appellant through ██████████.

Additionally, even if ██████████ is not available through ██████████, the record fails to demonstrate that she is treating Appellant for a serious medical condition, *i.e.* one that is grave, complex, or life threatening; manifests symptoms needing timely intervention to prevent complications or permanent impairment; or is the acute exacerbation of a chronic condition. Instead, she merely indicated that Appellant's chronic condition of lupus causes itching and break-outs on Appellant's skin, without any suggestion that the condition carries an immediate risk to Appellant's health or that the fluctuating flare-ups do not respond to well-known standard medical treatment protocols.

Appellant must meet all of the conditions outlined in the law to be granted an exception. She failed to do so in any of the six requests for exception in this case and, consequently, the Department's decision to deny those requests must be affirmed.

[REDACTED]
Docket No. 2014-35753 MCE
Decision and Order

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's requests for medical exceptions from mandatory Managed Care Program enrollment.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Steven Kibit

Steven J. 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 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.