

**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:**

██████████,

Appellant

\_\_\_\_\_ /

**Docket No.** 2014-5860 QHP

██████████

██████████

**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.*, and upon the Appellant's request for a hearing.

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

Following the hearing, the record was left open for ██████████ weeks so Appellant could have the opportunity to submit additional evidence and the MHP the opportunity to response to that evidence. No additional evidence was received by MAHS prior to the record closing.

**ISSUE**

Did the MHP properly deny the Appellant's request to be reimbursed ██████████ for the costs of a surgery and, instead, only reimburse Appellant ██████████ pursuant to the Michigan Department of Community Health's Medicaid Fee Schedule?

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who has been enrolled in the Respondent MHP at all times relevant to this matter. (Respondent's Exhibit A, page 19).

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2. On ██████████ Appellant injured his knee while traveling in the state of ██████████. (Testimony of Appellant's representative).
3. Appellant went to an emergency room at ██████████ where he was treated and discharged. (Testimony of Appellant's representative).
4. That hospital stay was covered by the MHP. (Respondent's Exhibit A, page 7; Testimony of Appellant's representative).
5. ████████ days later, on ██████████, Appellant was admitted to the ██████████. (Respondent's Exhibit A, page 7; Testimony of Appellant's representative).
6. During his stay at that ██████████ hospital, Appellant underwent ██████████ surgeries. (Testimony of Appellant's representative).
7. The hospitalization and ██████████ surgery were covered by the MHP. (Respondent's Exhibit A, page 7; Testimony of Appellant's representative).
8. Appellant and his wife wanted a ██████████ to perform the ██████████ surgery. (Testimony of Appellant's representative).
9. On ██████████ performed the ██████████ surgery. (Respondent's Exhibit A, pages 15-17).
10. ██████████ does not participate with any insurance plans and, on ██████████, billed Appellant for ██████████ (Respondent's Exhibit A, page 13; Testimony of Appellant's representative).
11. Appellant then paid ██████████ directly to ██████████ by credit card. (Respondent's Exhibit A, pages 13-14; Testimony of Appellant's representative).
12. ██████████ never submitted any claims to the MHP. (Testimony of ██████████)
13. In ██████████, the Michigan Department of Insurance and Financial Services (DIFS) received a complaint filed by Appellant against the MHP. (Respondent's Exhibit A, pages 10-20).
14. On ██████████, DIFS sent written notice to the MHP advising it of the complaint and requesting a response within ██████████ calendar days. (Respondent's Exhibit A, page 10).
15. On ██████████, the MHP submitted its response to DIFS. (Respondent's Exhibit A, pages 8-9).

16. In that response, the MHP indicated that ██████████ has never submitted a claim to the MHP for his services and that, when the MHP requested such a claim, the doctor's office refused to make one. (Respondent's Exhibit A, page 8).
17. The MHP's response also indicated that, as Appellant's complaint included a billing statement from ██████████ office, it would now process that bill and reimburse Appellant at the Michigan Department of Community Health's Reimbursement Rate. (Respondent's Exhibit A, page 8).
18. The reimbursement amount came to ██████████ and a check was issued to Appellant. (Respondent's Exhibit A, pages 8-9).
19. On ██████████ DIFS received a request from Appellant for an external review pursuant to the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* (Respondent's Exhibit A, page 10)
20. After a preliminary review, the Director of DIFS accepted the request on ██████████. (Respondent's Exhibit A, page 3).
21. The Director also received the MHP's response on ██████████. (Respondent's Exhibit A, page 3).
22. On ██████████, the DIFS' Special Deputy Director, issued an Order affirming the MHP's final determination and finding that the MHP is not required to provide any additional payment for the medical services performed by ██████████ in ██████████ (Respondent's Exhibit A, pages 3-6).
23. That Order also notified Appellant of his right to appeal the final administrative decision to a Circuit Court. (Respondent's Exhibit A, pages 5-6).
24. On ██████████ the Michigan Administrative Hearing System (MAHS) received a complete and signed request for hearing in this matter. (Petitioner's Exhibit 1, page 1).
25. In that request, Appellant asserted that the MHP failed to make full reimbursement for a preapproved surgery and that it only paid ██████████ out of a ██████████ bill. (Petitioner's Exhibit 1, page 1).
26. Appellant seeks full reimbursement of the billed costs for his ██████████ surgery. (Petitioner's Exhibit 1, page 1).

## **CONCLUSIONS OF LAW**

As a preliminary matter, this Administrative Law Judge would note that the MHP asserts that the issue on appeal in this case has already been decided in the ██████████ Order of Special Deputy Director ██████████ and that Appellant is therefore barred from raising the issue again. However, while it is true that Appellant's request for hearing in this case is similar to Appellant's request for external review pursuant to the PRIRA, the issues raised in the two matters are distinct and Respondent fails to point to any specific legal authority prohibiting this appeal. Accordingly, this Administrative Law Judge will not dismiss this case on that basis.

Moreover, while the Code of Federal Regulations (CFR) only affords a Medicaid beneficiary a right to a fair hearing when the Department takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service, an "Action" includes the "denial, in whole or in part, of payment for a service". 42 CFR 438.400(b)(3). That is what Appellant alleges occurred in this case and this Administrative Law Judge therefore finds that he has jurisdiction.

With respect to that jurisdiction, the Medical Assistance Program was 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 Michigan Department of Community Health 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 MHPs.

The Respondent is one of those MHPs and 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.

### **1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)**

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services

- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral-maxillofacial surgeons)
- Prosthetics and orthotics

- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for individuals under age 21

*Medicaid Provider Manual (MPM), July 1, 2013 version  
Medicaid Health Plans Chapter, pages 1-2*

However, while the above services are covered services, they must also be medically necessary in a particular case. Moreover, as stated in the above policy, “MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements” in approving services.” MPM, July 1, 2013 version, Medicaid Health Plans Chapter, page 1.

Here, Appellant’s representative testified that the MHP specifically approved the request that ██████████ perform the surgery, with full knowledge of both the fact that the doctor did not participate with any insurance plans and of the cost of the surgery. In her testimony, Appellant’s representative also elaborated on the reasons why she and Appellant wanted ██████████ to perform the surgery.

While acknowledging that the surgery itself was medically necessary and covered, the MHP’s witness testified that no specific approval of ██████████ rates ever occurred. He also testified that the MHP never would have approved such a billing rate given its policies and the lack of medical necessity in having ██████████ perform the surgery.

With respect to the issue in dispute, Appellant has the burden of proving by a preponderance of the evidence that the MHP erred by only partially reimbursing him. Here, given the record in this case, Appellant has failed to meet that burden of proof.

The MHP’s witness is much more credible regarding what was approved in this case. Given that there must be a significant number of doctors available in ██████████ who could have perform the necessary surgery and who would have accepted the MHP’s

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rate, it makes little sense that the MHP would have approved [REDACTED] rate prior to the surgery, even if Appellant preferred that [REDACTED] perform it. Appellant's preference does not equal medical necessity and the mere fact that the surgery is covered does not mean that Appellant can choose any doctor and that the MHP must reimburse any bill, regardless of the cost.

Moreover, the record was left open after the hearing so that Appellant's representative could have the opportunity to submit evidence of the alleged approval. She failed to submit any such evidence.

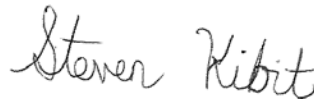
Appellant has the burden of proof in this case and given the lack of evidence supporting his representative's testimony, in addition to the MHP's witness' credible testimony that the MHP never approved [REDACTED] performing the [REDACTED] surgery at the stated billing rate and that it would never make such an approval, this Administrative Law Judge finds that Appellant and his representative have failed to meet their burden of proof. Accordingly, the MHP's decision must be sustained.

**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 to be reimbursed [REDACTED] for the costs of his [REDACTED] surgery and, instead, only reimbursed Appellant [REDACTED].

**IT IS THEREFORE ORDERED** that:

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



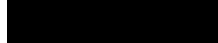
\_\_\_\_\_  
Steven Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

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**\*\*\* 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.