

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. 2014-7333 QHP

██████████

██████████

Appellant.

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on ██████████ ██████████ the Appellant's mother appeared and testified on the Appellant's behalf. ██████████ Director of Customer and Provider Services appeared and testified on behalf of ██████████ the Medicaid Health Plan (hereinafter MHP).

ISSUE

Did ██████████ properly deny Appellant's request to cover genetic testing?

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 born on ██████████ and was ██████ years-old at the time of the hearing. Appellant has been diagnosed with developmental delays and other unspecified health issues. (Exhibit 1 and testimony).
2. On ██████████, Appellant went to the ██████████ and underwent some genetic testing to help determine what might be causing the Appellant's developmental delays and possibly some of her other medical issues. (Exhibit A, pp. 1-2, Exhibit 1 and testimony).
3. On ██████████, the MPH received a claim for the genetic testing indicating Date of Service: ██████████ Procedure Code: ██████████ Charge: ██████████, and Provider: ██████████. The claim was processed and denied for other insurance primary. (Exhibit A, p. 2 and testimony).

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4. On ██████████, the MPH processed the claim again from the ██████████ and denied the claim as the genetic testing was not a covered benefit. (Exhibit A, p. 3 and testimony).
5. On ██████████, Appellant's mother contacted the MPH about the bill she received for ██████████ to cover the genetic testing at the ██████████. Appellant's mother did not obtain prior authorization and indicated that she had already paid the bill. (Exhibit A, p. 3 and testimony).
6. On ██████████, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed on behalf of Appellant. (Exhibit 1).

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 in one of those Medicaid Health Plans and, regarding such plans, the Michigan Medicaid Provider Manual states:

SECTION 1 – GENERAL INFORMATION

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

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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. [*Medicaid Provider Manual, Medicaid Health Plan (MHPs)*, April 1, 2013, p. 1 (emphasis added)].

With respect to [REDACTED] prior authorization requirements, [REDACTED] Director of Customer and Provider Services testified that their MHP required prior authorization for genetic testing. Accordingly, requests for genetic testing are subject to medical review by [REDACTED] who will make an authorization decision and return the referral to the requesting practitioner prior to the service being provided. [REDACTED] indicated that there was no request for prior authorization on file for the Appellant's genetic testing done on [REDACTED] by the [REDACTED] and no diagnosis, medical information or plan of care was ever received by [REDACTED] in regards to the Appellant's genetic testing.

Appellant's mother testified she went back and forth with the insurance companies to try to find out who was covering the Appellant at the time of the genetic testing, i.e., who was the primary insurance carrier. Appellant's mother indicated she did not know how to determine if the Appellant needed a prior authorization for the genetic testing. She indicated there was not any clear information indicating the genetic testing was not a covered benefit without prior authorization. Appellant's mother stated she does not know whether this matter was handled fairly or not.

Pursuant to the above policy, [REDACTED] denied Appellant's request on the basis that, there was no prior authorization. Also the timeliness of the appeal is questionable since the denial was on [REDACTED], and the Appellant's appeal was not filed until [REDACTED]. But for the MPH's acknowledgement that no written notification was sent to the Appellant concerning the [REDACTED] denial, this matter would have resulted in a dismissal for an untimely appeal.

Appellant bears the burden of proving by a preponderance of the evidence that [REDACTED] erred in denying her request to cover the genetic testing that was obtained without prior authorization. Here, Appellant has failed to meet that burden of proof. Accordingly, the MPH's denial must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [REDACTED] properly denied Appellant's request to cover the genetic testing done on [REDACTED] by the [REDACTED]

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IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/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.