STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 14-016934 MHP

[redacted]

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 a request for hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted], Grievance Coordinator, appeared and testified on behalf of [redacted], the Respondent Medicaid Health Plan (MHP). [redacted], Clinical and Quality Review Specialist, also testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for home physician visits?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. On [redacted], Appellant enrolled in the MHP. (Testimony of [redacted]

2. On or about [redacted], the MHP received a prior authorization request submitted on Appellant's behalf by a [redacted]. (Testimony of [redacted].

3. In that request, Appellant and [redacted] asked for coverage of home physician visits to be performed by [redacted] (Testimony of [redacted]

4. However, in reviewing the request, the MHP discovered that [redacted] was not an enrolled provider within its network and that Appellant did not have a primary care physician within the network. (Testimony of [redacted]).

5. The MHP then sent Appellant and [redacted] written notice that the request was denied on the basis that, per its policy, any out-of-network services had to be both medically necessary and directed by Appellant's primary care physician. (Testimony of [redacted].

6. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing with respect to the denial. (Exhibit 1, pages 1-2).

7. After receiving the request for hearing, the MHP reviewed Appellant's request and assigned her a case manager, who assisted Appellant in acquiring a primary care physician within the MHP's network. (Testimony of [redacted]

8. Also, as the first visit with the primary care physician was scheduled for [redacted] the MHP approved three home physician visits with [redacted] (Testimony of [redacted]

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. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> *MPM, January 1, 2015 version*
> *Medicaid Health Plan Chapter, page 1*
> *(Emphasis added by ALJ)*

Moreover, with respect to MHPs and out-of-network services, the MHP also specifically provides:

> **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, January 1, 2015 version
Medicaid Health Plan Chapter, page 5

Pursuant to the above policies, the MHP has developed utilization management/review criteria. Additionally, as part of its procedures, the MHP requires both that members obtain plan authorization prior to receiving services from out-of-network providers and that each member select a primary care physician, who is responsible for coordinating all health services.

The MHP's witnesses also testified that the denial in this case was based on those guidelines. Specifically, they noted that the request failed to identify any medical necessity for out-of-network services given the availability of network providers who could provide care and that the request was not made by Appellant's primary care physician.

Appellant's representative bears the burden of proving by a preponderance of the evidence that the MHP erred in denying the prior authorization request.

In this case, Appellant's representative testified regarding the need to have a physician come to Appellant's home due to her health needs and risks associated with having her travel, especially with unreliable transportation.

However, the denial in this case was not based on a lack of medical necessity for home physician visits. Appellant's representative also does not dispute that [redacted] is not a network provider with the MHP or that Appellant did not have a primary care physician within the MHP.

Accordingly, given the clear guidelines applicable to this case, the MHP's decision must be affirmed. To the extent Appellant requires home physician visits, she can always have her primary care physician those services and, if necessary, file a new request for hearing.[1]

[1] The MHP's witnesses also testified that Appellant dis-enrolled from the MHP effective [redacted]. Appellant's representative could neither confirm nor deny that testimony. To the extent Appellant switched health plans, she would need to request the services through her new plan.

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 request for home physician visits.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.