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. 15-001367 MHP

[redacted] [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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared and testified on her own behalf. [redacted], Medicaid Manager, appeared and testified for the Medicaid Health Plan (MHP), [redacted].

ISSUE

Did the MHP properly deny the Appellant's request for an Out-of-Network consultation with U[redacted]?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted]-year-old (DOB 1[redacted]) Medicaid beneficiary receiving services under the Healthy Michigan Plan. (Exhibit A, p. 6, 55-60 and testimony).

2. On [redacted], the MHP received a Prior Authorization (PA) Request from [redacted], on behalf of the Appellant for an Out-of-Network consultation with [redacted]. (Exhibit A, pp. 1, 5-18 and testimony).

3. On [redacted], denial letters were sent to the Appellant, the Appellant's doctor and the Out-of-Network provider. The reason for the denial was that [redacted] was an Out-of-Network provider and the referral by the Appellant's primary care physician was

not sufficient for coverage of services received from a non-participating provider. (Exhibit A, pp. 1, 20-21 and testimony).

4. On [redacted], the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 3).

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.

On May 30, 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 MHPs.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:
>
> - The prevention, diagnosis, and treatment of health impairments
> - The ability to achieve age-appropriate growth and development
> - The ability to attain, maintain, or regain functional capacity
>
> The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified.

The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids (only for enrollees under 21 years of age)
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services

- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21 [Article 1.020 Scope of [Services], at §1.022 E (1) contract, 1/23/2013, pp. 22-23].

* * *

AA. Utilization Management

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for

> authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *supra,* p. 55].

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior authorization request under Priority Health's Medicaid Handbook and Certificate of Coverage, Section 2, Obtaining Covered Services, C. Referrals. (Exhibit A, pp. 1, 20-21, 23-24).

Respondent's witness and the documentary evidence admitted during the hearing establish that on [redacted], the MHP received a Prior Authorization (PA) Request from [redacted], on behalf of the Appellant for an Out-of-Network consultation with [redacted]. On J[redacted], denial letters were sent to the Appellant, the Appellant's doctor and the Out-of-Network provider. The reason for the denial was that [redacted] was an Out-of-Network provider and the referral by the Appellant's primary care physician was not sufficient for coverage of services received from a non-participating provider.

Mr. Greshak stated the MHP reviewed the prior authorization request under Priority Health's Medicaid Handbook and Certificate of Coverage, Section 2, Obtaining Covered Services, C. Referrals. He further stated that the referral to the [redacted], a non-participating provider was denied because the accepted standard of care is available within the [redacted] Network of providers. [redacted] stated that the information submitted by the Appellant's doctor did not indicate that the Appellant had seen any providers who are participating providers with [redacted]. He did state, however, that his search of [redacted] records showed that the Appellant had seen a [redacted] who is a provider in [redacted] network.

The Appellant testified that she did see [redacted] and some other doctors specializing in Gastroenterology in [redacted] network, but she could not recall their names. Appellant said the doctors she had seen were not getting to the root of her medical problems and she wanted to go to [redacted] for a consultation. Appellant said her mother also had Chron's Disease and had some success with her problems when she went to the [redacted] Hospital, so she wanted to go to [redacted]

The Appellant failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her PA request for an Out-of-Network consultation with [redacted]. [redacted] was an Out-of-Network provider and the accepted standard of care is available within the [redacted] Network of providers. Furthermore, the information submitted with

the Appellant's PA request did not indicate she had been seen by in-network providers, or that such providers were unable to assist her with her medical condition. Accordingly, the PA request did not meet the coverage criteria under [redacted] Medicaid Handbook and Certificate of Coverage.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for an Out-of-Network consultation with [redacted] was proper based on the information submitted by her doctor along with the PA request.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, 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.