STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-013031 MHP
Case No. [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] Minor Appellant was represented by [redacted], parent.

The Department's subcontractor-[redacted]. of Flint, Michigan (Respondent or MHP), was represented by [redacted], Associate General Counsel. [redacted], Appeals Grievance Coordinator, appeared as a witness. [redacted], Supervisor of Appeals and Grievances for Molina Health Care of Michigan, observed.

ISSUE

Did the MHP properly deny the Appellant's request for continuing out of network provider services to see an Orthopedic Surgeon?

FINDINGS OF FACT

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

1. Health Plus, Inc. of Michigan is a Qualified Medical Health Plan contracted with the State of Michigan Comprehensive Health Care Program.

2. Appellant is a [redacted] Medicaid benefit recipient who was an enrolled member of Health Plus, Inc. at the time of the request for services and continues to be enrolled.

3. Appellant has a diagnosis of left [redacted]. When Appellant was 3, Appellant was referred by [redacted] Chief of Pediatric Orthopedics with the University of Michigan Medical School to [redacted] of Baltimore, Maryland, with Sinai Hospital for treatment. Appellant had super ankle surgery and a tibial lengthening with [redacted] has had 4 surgeries, and has a plan of care established with [redacted] that includes ongoing treatment and surgeries.

4. [redacted] of Baltimore is an out of network physician.

5. Respondent MHP approved the following service dates with out of network [redacted]: [redacted] through [redacted]; [redacted] through [redacted]; [redacted] through [redacted]. (Exhibit A.1).

6. On [redacted], the MHP received a Prior Authorization request from Appellant's primary physician again for 9 visits between [redacted] and [redacted] with [redacted]., including surgery for metatarsal syndactyly. (Exhibit A.12-13).

7. On [redacted] the MHP denied the Prior Authorization request the reason that services are available in-plan. (Exhibit A.16-18).

8. The MHP testified at the administrative hearing that it has determined that requested services are available at the University of Michigan by the University Ortho Surgery Clinic pursuant to a statement prepared [redacted] signed by [redacted] (Exhibit A.14-15). Appellant was referred on [redacted] for an assessment for curvature of the spine. (Appellant's Testimony).

9. On [redacted] Chief of Pediatric Orthopedics at University of Michigan Medical School stating in part: "[child] requires further surgery, and I am recommending [redacted] to do the surgery. She [Appellant] has extensive foot deformities and has a residual leg length deformity…I wholeheartedly support this as [redacted] has been her doctor for a very long time, and offers a unique treatment for this difficult deformity."

10. On [redacted], Appellant filed a request for a hearing with the Michigan Administrative Hearing System to contest the Respondent's denial. (Exhibit a.3).

11. An internal review conducted after Appellant filed her hearing request cites Corporate Policy 4127, the medical necessity determination process requiring affiliated providers and/or practitioners for services except in the following circumstances: i) equivalent services are not available in-plan; ii) out-of-plan services are necessary to assure continuity of care for an individual in an active phase of treatment; iii) CSHCS enrollees; iv) the member's …and v) second opinions. (Exhibit A.35).

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 [redacted], 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. 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
> - 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
- 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, 2010, p. 22].

(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. 49].

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations."

In this case, Appellant, who is now [redacted], has been seeing [redacted] in Baltimore since she was [redacted]. Evidentially, Appellant has had 4 surgeries, and based on the plan of services, will need more. Evidence indicates that [redacted] Chief of Pediatric Orthopedics at the University of Michigan initially referred Appellant. Unrefuted evidence is that the MHP initially approved Appellant's treatment with Dr. Herzenberg, and, continued to approve a number of subsequent approvals.

However, the Respondent MHP has denied the most recent PA request of 6/12/15 on the grounds that in network services are available based primarily on Exhibit A.14-15, where nurse [redacted] completed a letter based on a [redacted] evaluation. At hearing, there was some confusion regarding the purpose of the assessment and the contents of this letter-Appellant's representative argues that she understood that Appellant was being assessed for curvature of the spine. Typically, customary practice is for a physician to note at the onset of an evaluation the purpose for which the patient sought out treatment; however, there is no such initial statement; the nurse who composed the letter fails to identify the purpose for which Appellant was evaluated.

In support of her position and as clarification, Appellant offered a letter written by the Chief of Pediatric Orthopedics, [redacted] at the University of Michigan who is over the services discussed in the nurse's letter. As noted in the Findings of Fact, [redacted] initially referred Appellant to [redacted] when Appellant was [redacted]. In the letter, [redacted] recommends that Appellant see and continue with [redacted] for "further surgery," and states that [redacted] offers a "unique treatment" for Appellant's diagnosis.

Regarding the continuity of care issue, it is noted that this reason was not stated on the initial denial of [redacted]. Nor is it specifically identified in the Medicaid Provider

Manual General Information for Providers Chapter, Section 7.3 out of state/beyond borderland providers provision. However, it is contained in the subcontractor's definition of terms and corporate policy (4127) (See Exhibit A.35). Evidence indicates that Appellant has been treated by [redacted] since she was [redacted] (for 4 years). In addition, Appellant was in fact approved by the Respondent MHP a number of times, and is continuing to be referred to [redacted] by the very network staff that the MHP is arguing can provide "equivalent services." [redacted] of the University of Michigan Medical School, specifically states that she recommends that Appellant continue with [redacted] as [redacted] has been Appellant's "…doctor for a very long time, and offers a unique treatment for this difficult deformity." The University of Michigan pediatric head of the department states that [redacted] treatment is unique. This ALJ does not find the meaning of 'unique' to be commensurate with 'equivalent'.

After a careful review of the credible and substantial evidence of the whole record, Appellant has failed go forward to show that the reason given for denial is supported by credible and substantial evidence of record. Appellant was initially referred by the University of Michigan to [redacted] was previously approved by the MHP for a number of service plans, and, the University of Michigan head pediatric surgery continues to recommend that Appellant see [redacted] for continuing care as [redacted] offers a unique treatment.

The decision to deny the request for authorization is not consistent with the MPM and the Respondent guidelines.

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 out of network services was not proper.

IT IS THEREFORE ORDERED that:

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

Janice G. Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Mailed: [redacted]

[redacted]

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.