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

IN THE MATTER OF:

Docket No. 15-007613 MHP

[redacted] [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.,* and upon Appellant's request for hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] Appellant's mother, also testified as a witness for Appellant. [redacted], paralegal, appeared on behalf of [redacted], the Respondent Medicaid Health Plan (MHP). [redacted] Medical Director, testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's requests for services at an out-of-network clinic?

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 is an enrolled beneficiary with the MHP. (Undisputed testimony).

2. Appellant or her doctors have submitted three prior authorization requests to the MHP for treatment for Appellant at the [redacted] in [redacted] (Undisputed testimony).

3. The [redacted] is not an enrolled provider in the MHP's network. (Undisputed testimony).

4. The MHP subsequently sent Appellant written notices that the prior authorization requests were denied on the basis that Appellant could

receive the requested care through in-state and in-network providers. (Undisputed testimony).

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-2).

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 statutes, 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 and, as part of those procedures, the MHP requires that members obtain plan authorization prior to receiving services from out-of-network providers, as it is specifically allowed to do under the MPM. Moreover, as testified to by [redacted], the MHP review criteria provides that requests for services for out-of-network providers will be denied where the services are available within the MHP's network of providers.

The MHP's witness also testified that the denial in this case was based on those guidelines. Specifically, he noted that there was no prior authorization given for the out-of-network services; the services could have been provided in-network, and that none of the exceptions identified in the MPM or the MHP's criteria apply.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying her requests for coverage.

Here, Appellant first testified that, once it became clear that surgery was necessary, her doctor referred her to the [redacted] and she followed his recommendations in going there. However, that referral does not constitute a prior authorization from the MHP and the doctor's recommendation alone does not demonstrate a medical necessity for out-of-network services. Similarly, while Appellant credibly testified that she is now comfortable with the doctors at the [redacted], especially since they have completed all the tests and preparation for surgery, that comfort and preference also does not constitute a medical necessity for out-of-network services and Appellant has offered no evidence that the services can only be provided out-of-network.

Appellant and her representative also testified that they were told by the [redacted] that the treatment and surgery were approved by the MHP. However, they provided no other evidence of such an approval, in writing or otherwise. Appellant also could not provide details regarding the alleged verbal prior authorization, such as who gave it or when. [redacted] also credibly testified that, based on the MHP's records, no prior authorization was given and, given that the services were available in-network, the MHP would not approve the out-of-network services.

Appellant further testified that she has spoken to in-network providers in [redacted], but that they are planning on making her repeat tests that were already performed at the [redacted] which is something that Appellant does not want to do. However, even if true, that does not demonstrate that the MHP erred or that there is a medical necessity for out-of-network services In response, the MHP's representative also offered to have a case manager assist Appellant in gathering the necessary paperwork and working with the medical providers so that Appellant can avoid retesting if possible.

Accordingly, given the record in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that the MHP's decisions must therefore be affirmed.

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 requests for services at an out-of-network clinic.

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 Health and Human Services

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.