STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax: (517) 373-4147

IN THE MATTER OF:

MAHS Docket No. 15-020193 MHP

[redacted] [redacted] [redacted]

Appellant

[redacted]/

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 telephone hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted] Lead Grievance and Appeals, appeared and testified on behalf of [redacted], the Respondent Medicaid Health Plan (MHP).

ISSUE

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

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 a f[redacted]-year-old Medicaid beneficiary who is enrolled in the Respondent MHP. (Exhibit A, page 8).

2. On or about [redacted], Appellant's primary care physician, [redacted], submitted a prior authorization request to the MHP on Appellant's behalf. (Exhibit A, pages 8-17).

3. Specifically, the request was for a consultation for Appellant with a [redacted] at [redacted]. (Exhibit A, pages 8-17).

4. On or about [redacted] another medical provider, [redacted], submitted a prior authorization request to the MHP on Appellant's behalf. (Exhibit A, pages 22-39).

5. That request was for occupational therapy for Appellant at the [redacted]. (Exhibit A, pages 22-39).

6. On [redacted], the MHP sent Appellant written notice that the prior authorization request for a consultation with [redacted] was denied. (Exhibit 1, pages 2-3; Exhibit A, pages 19-20).

7. On [redacted] the MHP sent Appellant written notice that the prior authorization request for occupational therapy was denied. (Exhibit A, pages 41-42).

8. In each denial, the same reason was given for the MHP's decision:

> Information reviewed by us shows the [redacted] of the [redacted] is not a participating provider and the accepted standard of care is available within the [redacted] of providers. Therefore, we are unable to approve this request for out of network services.
>
> *Exhibit 1, page 2*
> *Exhibit A, pages 19, 41*

9. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, pages 1-3; Exhibit A, pages 4-6).

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, October 1, 2015 version*
> *Medicaid Health Plan Chapter, page*
> *(Emphasis added)*

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, October 1, 2015 version
Medicaid Health Plan Chapter, page 5

Pursuant to the above policies, the MHP has also 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 Respondent's representative and outlined in its Certificate of Coverage, the MHP review criteria further 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 representative also testified that the denial in this case was based on those guidelines. Specifically, he noted that, while the prior authorization requests were for services from out-of-network providers, the requested services could be provided within the MHP's 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 services.

Here, Appellant testified that, while the requests in this case were for services from providers out of the MHP's network, the types of doctors and the level of care she needs are very specialized. She also testified that she wants the best care and that the providers identified by the MHP do not have the record of doing surgeries like the one she had. Appellant further testified that her care should not be lower simply because she is on Medicare or Medicaid.

However, while the undersigned Administrative Law Judge appreciates both Appellant's concerns and her comfort level with the requested medical providers, neither her testimony nor the prior authorization requests demonstrate a medical necessity for the requested out-of-network services. The requests and supporting medical

documentation discuss Appellant's care without any assertion, or even any suggestion, that the care could only be provided out-of-network. Similarly, while stating her preference, Appellant has offered no evidence that the services can only be provided out-of-network.

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 the requests for out-of-network services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

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.