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. 15-021127 MHP
Agency Case No.

,

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

ISSUE

Did the MHP properly deny Appellant's request 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 year-old Medicaid beneficiary who is enrolled in the Respondent MHP. (Exhibit A, p. 8)

2. On , Appellant's orthopaedic physician, , submitted a prior authorization request to the MHP on Appellant's behalf. (Exhibit A, p. 7-9)

3. Specifically, the request was for an office visit for Appellant with Neurology Department for continuation of care. (Exhibit A, p. 8)

4. On , Appellant's orthopaedic physician, submitted additional information to the MHP to support the prior authorization request. (Exhibit A, p. 11-14)

5. On , the MHP sent Appellant written notice that the prior authorization request for a consultation with the was denied. The denial stated that the is not a participating provider and the accepted standard of care is available within the Priority Health Network of providers. Therefore, the MHP was unable to approve this request for out of network services. (Exhibit A, pp. 16-17)

6. On the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, pp. 3-5)

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 Health and Human Services (MDHHS) 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 MDHHS 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 Plans Chapter, p. 1
(Emphasis added)

Regarding MHPs and out-of-network services, the MPM 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 Plans Chapter, p. 5

Pursuant to the above policies, the MHP requires that members obtain prior authorization to receive services from out-of-network providers. As noted by the MHP's representative, the Priority Health Healthy Michigan Plan Handbook and Certificate of Coverage, referrals setion, advises members that they should not go to another participating or non-participating provider unless their primary care physician has referred them and the MHP has approved the referral first when they consider it necessary. (Exhibit A, p. 21) Additionally, the exclusions from coverage section specifies that services and supplies from non-participating providers are excluded except in the case of: a) medical emergency or if approved by the MHP in writing prior to obtaining the services and supplies; b) the treatment of communicable diseases such as TB or immunization services received at a local health department; c) family planning services or the treatment of sexually transmitted diseases received at a plan-approved family planning center or at a local health department; and d) services or supplies obtained from local health departments, tribal health centers or FQHCs. (Exhibit A, pp. 22-23)

The MHP's representative explained that Appellant's prior authorization request for an office visit with the [redacted] Neurology Department was denied because the requested provider is not a participating provider and the accepted standard of care is available within the MHP's network of providers. None of the exceptions identified in the MPM or the MHP's criteria applied. The MHP's representative noted that many participating neurologist providers were identified within 50 miles of Appellant's address. Additionally, there are other participating neurologist providers that are in-network beyond 50 miles from Appellant's address, including other tertiary care centers, such as [redacted], [redacted] and [redacted]. (Testimony of MHP's Representative; Exhibit A, pp. 25-30)

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

Appellant testified that her doctor stated he was only comfortable sending her to a larger health care center, specifically the [redacted], [redacted], or the [redacted]. Appellant explained that based on her symptoms, the referring doctor believed Appellant's autoimmune system was attacking her nervous system and it was imperative that she get to a specialist right away. The doctor indicated that she needed to be seen at a larger hospital and there would be too long of a wait with the local specialists. Appellant also described the ongoing changes with her condition. (Appellant Testimony)

While this ALJ sympathizes with the Appellant's circumstances, the request for an office visit with the [redacted] Neurology Department must be upheld. The available evidence did not establish medical necessity for the services to be provided by the requested provider, [redacted] Neurology Department. This is an out of network provider and the accepted standard of care is available within the MHP's network of providers, which does include other large hospital/tertiary care centers.

There was no evidence establishing that the requested services could only be provided by the requested out of network provider.

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 decision 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 request for out-of-network services.

IT IS THEREFORE ORDERED that:

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

Colleen Lack
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of
Health and Human Services

Date Mailed:

CL/cg

cc:

***** 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.