RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: [redacted]
MAHS Docket No.: 16-000740
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], the Petitioner, appeared on his own behalf. [redacted], Medical Social Worker, appeared as a witness for Petitioner. [redacted], Paralegal, represented [redacted], the Medicaid Health Plan (MHP). [redacted], Medical Director, appeared as a witness for the MHP.

During the hearing proceedings, the MHP's Hearing Summary packet was admitted as Exhibit A, pp. 1-40.

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for inpatient admission and care from non-network, non-borderland, out of state providers?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a Medicaid beneficiary who has been enrolled in the Respondent MHP since [redacted]. (Exhibit A, p. 1)

2. On [redacted], the MHP received Petitioner's Pre-Operative Evaluation and accompanying medical records for a planned recto urethral fistula repair at [redacted]. (Exhibit A, p. 9-32; Testimony)

3. On [redacted], the MHP sent Petitioner written notice that the prior authorization request for an elective inpatient admission was denied. The denial stated that the doctors and hospital Petitioner wanted to see are not part of the MHP's network of approved providers; this is not allowed except when you cannot get care from the MHP's group of providers; and it was expected that the in-network providers would be able to take care of Petitioner's problem. Therefore, the request could not be approved at that time. (Exhibit A, p. 5)

4. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, p. 4)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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 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, January 1, 2016, version*
> *Medicaid Health Plans Chapter, p. 1*

Regarding out of state/beyond borderland providers, the MPM provides:

> **7.3 OUT OF STATE/BEYOND BORDERLAND PROVIDERS**
>
> Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDHHS reimburses out of state providers who are beyond the borderland area (defined below) if the service meets one of the following criteria:
>
> - Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
> - Medicare and/or private insurance has paid a portion of the service and the provider is billing MDHHS for the coinsurance and/or deductible amounts; or
> - The service is prior authorized by MDHHS. MDHHS will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.
>
> *MPM, January 1, 2016, version*
> *General Information for Providers Chapter, pp. 14-15.*

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.
>
> **2.6.B. HOSPITAL SERVICES**
>
> MHPs reimburse hospitals according to the terms of the contract between the MHP and the hospital. If a hospital does not have a contract with an MHP but has signed a hospital access agreement with MDHHS, the following conditions apply:
>
> - The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid beneficiaries enrolled in MHPs with which the hospital does not have a contract.
> - MHPs agree to continue to use network-contracted providers when available and appropriate.

- The hospital will be entitled to payment by MHPs for all covered and authorized (if required) services provided in accordance with their obligations under the agreement.
- A rapid dispute resolution process will be available for hospitals and MHPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- MHPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. The payment for inpatient stays includes the relevant DRG and capital costs.

Copies of the Hospital Access Agreement, Health Plan Obligations, and Rapid Dispute Resolution are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Hospitals that have signed the Hospital Access Agreement and the MHPs are required to abide by the terms and conditions of the Agreement.

MPM, January 1, 2016, version
Medicaid Health Plans Chapter, pp. 5-6.

Pursuant to the above policies, the MHP requires that members obtain prior authorization to receive services from out-of-network and non-borderland, out of state providers. As noted by the MHP's representative, the MPM policy and the [redacted] Community Plan Certificate of Coverage, do not support approval of the [redacted], prior authorization request based on the information available at that time. Specifically, the MHP only received documentation from [redacted], an out-of-network, non-borderland, out of state provider. There was insufficient documentation to establish that the requested services were not available from any Michigan or borderland area providers. (Testimony and Exhibit A, pp. 33-40 and 9-32)

Petitioner had surgery for prostate cancer, then had a rectourethral fistula, which needs to be repaired. It was explained that Petitioner had been [redacted] resident and received Medicaid though that state. Accordingly, Petitioner was originally not out of network for the [redacted] to perform the repair surgery because he was an [redacted] Medicaid beneficiary. (Testimony and Exhibit A, p. 15)

However, Petitioner began staying with his brother in Michigan, who was helping to care for him after the original surgery. Petitioner was then notified that his [redacted] Medicaid would be closed because he was now living in Michigan. Petitioner was approved for Medicaid though the state of Michigan. Petitioner has been enrolled in the Respondent MHP since [redacted]. (Testimony and Exhibit A, p. 1)

While this history helps explain why the only documentation submitted to the MHP was from [redacted], there was insufficient documentation to support an approval of the [redacted], prior authorization request. The submitted information did not establish that the requested services were not available from any Michigan or borderland area providers.

Petitioner bears the burden of proving by a preponderance of the evidence that the MHP erred in denying his request for services. While this ALJ sympathizes with the Petitioner's circumstances, the denial of the [redacted], request for inpatient admission and care from non-network, non-borderland, out of state providers must be upheld based on the information available at that time. The submitted information did not establish that the requested services were not available from any Michigan or borderland area providers. Accordingly, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that the MHP's decision for the [redacted], prior authorization request must therefore be affirmed.

As discussed during the hearing proceedings, if he has not already done so, Petitioner may wish to have a new prior authorization request submitted to the MHP from the referring primary care doctor or the [redacted] and attach the more recent documentation from the [redacted] that the needed services cannot be performed there.

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 inpatient admission and care from non-network, non-borderland, out of state providers.

IT IS, THEREFORE, ORDERED that:

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

Colleen Lack

CL/cg

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact [redacted]

Petitioner [redacted]

Community Health Rep [redacted]