RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed:
MAHS Docket No.: 16-002680
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

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 . Petitioner appeared and testified. Petitioner was represented by , non-attorney. , Grievance and Appeals Analyst appeared on behalf of the Respondent's subcontractor, the Medicaid Health Plan of Michigan (MHP or Respondent).

ISSUE

Did the Medicaid Health Plan properly deny billing for Petitioner's inpatient hospital stay from through ?

FINDINGS OF FACT

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

1. On , Petitioner was admitted to via the Emergency Room and discharged the following day.

2. On of Michigan was contacted by the hospital requesting authorization for an inpatient admission on dates of service .

3. On [redacted], the Health Plan's Medical Director denied the request for inpatient admission stating that although the admission meets guidelines for observation, the request is not consistent with guidelines for reimbursement of an inpatient admission. The Medical Director used Milliman Care Guidelines-Angina as a basis for the decision.

4. On [redacted] denial letters were sent to the member and the provider.

5. On [redacted] [redacted] submitted a claim for an observation level of care for dates of service [redacted] [redacted] The claim was processed and paid on [redacted].

6. On [redacted], [redacted] Grievance & Appeals Department received notice that a hearing had been requested by the member and his father, [redacted].

7. On [redacted] Grievance & Appeals staff contacted [redacted] [redacted] regarding the denial. [redacted] confirmed that he and his son had requested the hearing upon receiving the denial letter from the health plan. They were concerned that the member would be billed for the admission. [redacted] had not received an actual bill from the hospital.

8. The Health Plan staff assured [redacted] that his son cannot be billed for these services. [redacted] was advised that if his son receives a bill, he may contact the Grievance & Appeals Department for assistance.

9. On [redacted] Petitioner filed a request for an administrative hearing with MAHS.

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 Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors 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 1-Z.

Article II-G, Scope of Comprehensive Benefit Package.
MDHHS contract (Contract) with the Medicaid Health Plans, September 30, 2004.

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

Here, the MHP submitted evidence and authority under the Milliman Care Guidelines, Angina clinical criteria. This criteria does not allow for payment based on the inpatient level of acute care as evidentially Petitioner was admitted only for observation. Thus, the billing did not meet medical necessity and was properly denied.

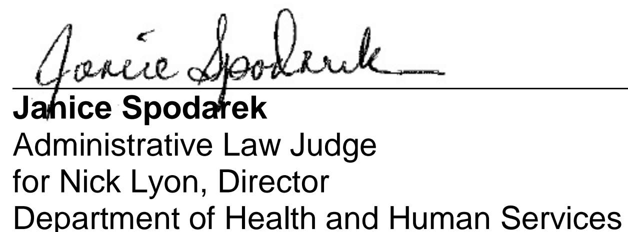
However, the hospital subsequently submitted billing for an amount under the observation guidelines, and the MHP has paid the bill. Petitioner understands that he is not responsible for this bill, and, that the [redacted] cannot and has no legal authority to request any payment from Petitioner with regard to the [redacted] stay. (Testimony by [redacted]).

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan's decision to deny the billing based on an acute stay was correct and is hereby **AFFIRMED; Petitioner has not responsibility for any bill related to his [redacted] stay at [redacted]**.



JS/cg

Janice Spodarek
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

Community Health Rep

Petitioner

Authorized Hearing Rep.