



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: May 17, 2016
MAHS Docket No.: 16-003548
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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]. Petitioner [REDACTED] and Witness [REDACTED] appeared on behalf of the Petitioner; [REDACTED], Grievance and Appeals Analyst; and Dr. [REDACTED], Medical director appeared to testify and represent [REDACTED], the Medicaid Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for out-of-network medical provider?

FINDINGS OF FACT

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

1. [REDACTED] of Michigan is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.
2. Petitioner is a Medicaid benefit recipient who was an enrolled member of [REDACTED] of Michigan at the time of the request for services and continues to be enrolled.
3. The [REDACTED] of Michigan member handbook and certificate of coverage were sent at the time of enrollment.

4. The [REDACTED] Member Handbook outlines covers limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.
5. On [REDACTED], [REDACTED] received a Prior Authorization request for a CT lower extremity.
6. On [REDACTED], Services requested by Dr. [REDACTED]'s office were denied by the health plan's Medical Director stating: The member is required to utilize in-network resources when possible. There is no documentation provided by Petitioner that these resources were unavailable or inadequate. There is nothing in Petitioner's Medical records to indicate that he has any prior treatment relationship with Dr. [REDACTED].
7. On [REDACTED], [REDACTED] sent Petitioner a letter stating that the request for out of network provider was denied because the services are not covered by [REDACTED] and will not be paid. Your provider cannot bill you for these services. We only pay for services that are 'medically necessary'. Criteria: The Medical Director used Administrative Decision that services could be provided by in-network provider or vendor clinical criteria to make this decision.
8. On [REDACTED], the Michigan Administrative Hearing System received a Request for Hearing.

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. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of

care. The Contractor 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 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services

- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21 [Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22].

(1) The major components of the Contractor's utilization management (UM) program 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 UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *Supra*, p. 49].

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations."

The member is required to utilize in-network resources when possible. There is no documentation provided by Petitioner that these resources were unavailable or inadequate. There is nothing in Petitioner's Medical records to indicate that he has any prior treatment relationship with Dr. [REDACTED].

[REDACTED] of Michigan has multiple contracted Rheumatologists within close distance of the member's home. A list of the providers was provided to Petitioner. There are no denied payment claims for Petitioner at this time. On [REDACTED], [REDACTED] was paid for dates of service [REDACTED] in accordance with the facility's contract with [REDACTED] of Michigan. Petitioner has no financial liability for these services.

Petitioner has failed to satisfy the burden of proving by a preponderance of the evidence that the MHP improperly denied the requested service. The Medicaid Health Plan (MHP) does not have discretion to approve Petitioner's request without documentation that the service cannot be provided by network providers. The decision to deny the request for out of network services must be upheld under the circumstances.

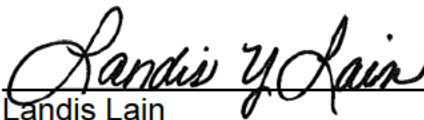
DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's original denial of the Petitioner's request for out of network services was proper.

IT IS THEREFORE ORDERED that:

The MHP's decision is **AFFIRMED**.

LL [REDACTED]



Landis Lain
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]

Community Health Rep

[REDACTED]

Authorized Hearing Rep.

[REDACTED]

Petitioner

[REDACTED]