RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: October 7, 2016
MAHS Docket No.: 16-009183
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 21, 2016. Petitioner appeared and testified on her own behalf. [redacted] Inquiry Dispute Appeal Resolution Coordinator, appeared and testified on behalf of [redacted], the Respondent Medicaid Health Plan (MHP).

ISSUE

Did Respondent properly deny Petitioner's request for payment for a nurse home visit?

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 was previously enrolled in the Respondent MHP. (Testimony of Petitioner; Testimony of Respondent's representative).

2. On [redacted], while Petitioner was enrolled with Respondent, a nurse conducted a home visit and provided services to Petitioner in Petitioner's home. (Exhibit A, page; Testimony of Petitioner).

3. The nurse was not within Respondent's network of contracted providers. (Testimony of Respondent).

4. On June 23, 2016, Respondent sent Petitioner written notice that a claim for payment for those services had been denied. (Exhibit A, pages 3-8).

5. Regarding the reason for the denial, the notice provided:

> The services you received were from an out-of-network provider. Services from out-of-network providers must be urgent or emergent in order to be covered, unless they are prior authorized. The services you received from this provider were not prior authorized and were not urgent or emergent.
>
> *Exhibit A, page 2*

6. On July 18, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that denial. (Exhibit 1, page 1; Exhibit A, page 2).

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 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 . . .

MPM, April 1, 2016 version
Medicaid Health Plans Chapter, page 1

Regarding Out-Of-Network Services, the MPM also provides in part:

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, April 1, 2016 version*
> *Medicaid Health Plans Chapter, page 5*

Respondent's Member Handbook similarly provides that out-of-network services are only approved when they are emergency services, urgently needed care; or authorized by Respondent prior to the services being provided. (Exhibit A, pages 9-13).

Here, Respondent denied Petitioner's request for payment for nursing services pursuant to the above policies and on the basis that the services were provided by an out-of-network provider, but were not emergent or authorized prior to them being provided. Respondent's witness also testified that she does not who know coordinated Petitioner's case or who Petitioner spoke to at the MHP, but that there was no prior authorization request in Petitioner's file and the claim submitted was denied.

In response, Petitioner testified that it was Respondent who initiated the services and made all the arrangements. Specifically, Petitioner testified that a representative from Respondent telephoned her in April of 2016 and said they wanted to send a nurse to Petitioner's home, even after she informed them that Petitioner had moved from [redacted] County to [redacted] County. Petitioner also testified that a different representative from Respondent telephoned her later to say when the nurse was coming out; the nurse subsequently came to Petitioner's home on [redacted]; and that Petitioner received a gift card from Petitioner for having the visit thereafter. Petitioner further testified that the next thing she received was a notice that payment had been denied, but that she has not yet been billed directly because she filed an appeal right away. Petitioner also confirmed that she is no longer enrolled with Respondent and that, prior to her enrollment being cancelled, she had no idea that Respondent did not cover [redacted] County.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for payment.

Given the available evidence and applicable policies in this case, Petitioner has failed to meet that burden of proof and the MHP's decision must be affirmed. It is undisputed that Petitioner received services from a nurse, but that the nurse was not within Respondent's network of contracted providers. Accordingly, per the above policy, the services would only be covered if they were emergency services, urgent care services or prior authorized by Respondent, and Petitioner has failed to demonstrate that any of those circumstances apply.

Petitioner does not assert that the services were emergency or urgent care services. She does argue that they were approved by Respondent, as Respondent was the one

who initiated the services in the April of 2016 and coordinated the care, with Petitioner neither requesting the services nor choosing the nurse, and that Petitioner should therefore not be responsible for them. However, Petitioner's testimony is otherwise unsupported, it lacks any pertinent details about who she spoke with or why the services were provided, and the undersigned Administrative Law Judge does not find that it alone meets Petitioner's burden of proof. Moreover, while Petitioner suggests that an error by Respondent regarding Petitioner's county of residence played a role in an out-of-network provider being used, Petitioner's location does not matter in this case and, regardless of where she lived, the provider's status as a network provider is what matters and that status is undisputed.

Petitioner has not yet been billed for any services and, to the extent the provider accepted her as a Medicaid patient, she may not be ultimately responsible for any bills. However, regardless of any future disputes, the decision at issue in this case must be affirmed given the lack of support for Petitioner's claims and her failure to demonstrate by a preponderance of the evidence that Respondent erred.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's request for payment for a home visit by a nurse.

IT IS, THEREFORE, ORDERED that:

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

SK/tm

Steven Kibit
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]

[redacted]

[redacted]