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: March 24, 2017
MAHS Docket No.: 17-000918
Agency No.:
Petitioner:

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 the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on March 14, 2017. Petitioner appeared and testified on her own behalf. , Lead Coordinator for Grievance and Appeals, appeared and testified on behalf of , the Respondent Medicaid Health Plan (MHP).

ISSUE

Did Respondent properly deny Petitioner's requests 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. Petitioner is a forty-two-year-old Medicaid beneficiary enrolled in the Respondent MHP. (Exhibit A, page 9; Testimony of Respondent's representative).

2. On December 28, 2016, Respondent received a prior authorization request submitted on Petitioner's behalf by a Dr. that requested a consultation with a gastroenterologist at the at the . (Exhibit A, pages 8-27).

3. On January 10, 2017, the gastroenterologist at the also submitted a

prior authorization request for an Esophagogastroduodenoscopy (EGD) for Petitioner. (Exhibit A, pages 32-36).

4. On January 11, 2017, Respondent sent Petitioner written notice that the first prior authorization request was denied. (Exhibit A, pages 29-30).

5. On January 23, 2017, Respondent sent Petitioner written notice that the second prior authorization request was denied. (Exhibit A, pages 38-39).

6. The reason for the denial given in both notices was that the information reviewed showed that the [redacted] was not a participating provider within the [redacted] of providers; the accepted standard of care is available within the network of providers; and the out-of-network services were therefore unnecessary. (Exhibit A, pages 5, 29, 38).

7. On January 31, 2017, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Petitioner with respect to those denials. (Exhibit A, pages 5-6).

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. <u>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</u>

> 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, 2016 version
Medicaid Health Plans Chapter, page 1
(Emphasis added by ALJ)

Moreover, with respect to 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, 2016 version
Medicaid Health Plan Chapter, page 5

Pursuant to the above policies, Respondent has also developed utilization management/review criteria and, as part of those procedures, Respondent requires that members obtain plan authorization prior to receiving services from out-of-network providers, as it is specifically allowed to do under the MPM. Moreover, as testified to by Respondent's representative and outlined in its Certificate of Coverage, the applicable review criteria further provides that requests for services for out-of-network providers will be denied where the services are available within Respondent's network of providers.

Respondent's representative testified that the denial in this case was based on those guidelines. Specifically, he noted that, while the prior authorization requests were for services from out-of-network providers, the requested services could be provided within the MHP's network, which has approximately 82 gastroenterologists within 50 miles of Petitioner's address, and that none of the exceptions identified in the MPM or the Respondent's criteria apply.

In response, Petitioner agreed that the requests in this case were for services from providers out of the Respondent's network. However, she also testified that one provider within the network previously committed malpractice with respect to her case and she is in the process of suing that provider. She further testified that Respondent has provided her a list of other network providers, but she has a complicated medical situation and wants to be treated by the best. Petitioner also asserted that she would either change her plan or acquire private insurance if her request is denied.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her requests for services.

Given the record and applicable policies in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed. While the undersigned Administrative Law Judge appreciates Petitioner's preference for particular providers that she may feel are the best, neither her testimony nor the prior authorization requests demonstrate any medical necessity for the requested out-of-network services. Petitioner has offered no evidence that any necessary services can

only be provided out-of-network and a mere preference for a particular provider is not enough to meet the applicable criteria.

Accordingly, given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that Respondent'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 Respondent properly denied Petitioner's prior authorization requests.

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan'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