[redacted]
MI [redacted]

Date Mailed: January 28, 2020
MOAHR Docket No.: 19-010992
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 January 22, 2020. [redacted], Petitioner's Authorized Hearing Representative (AHR), appeared on behalf of Petitioner. Jonathan Gruner, Attorney, appeared on behalf of McLaren (Respondent or Department). Melissa Sweet, Appeals Coordinator, appeared as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for Meals and Lodging related to a medical appointment?

FINDINGS OF FACT

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

1. At all times relevant to this proceeding, Petitioner resided in [redacted] MI. (Exhibit A; Testimony.)

2. On [redacted] 2019, Petitioner received treatment in the Emergency Room at [redacted] in Grand Rapids, MI. (Exhibit A; Testimony.)

3. [redacted] 2019 through [redacted] 2019, Petitioner received treatment at the [redacted] in Grand Rapids, MI. (Exhibit A; Testimony.)

4. From January 6, 2019 through January 8, 2019, Petitioner stayed at the [redacted] in Mount Pleasant, Michigan. During this stay, Petitioner ate at the Resort; Bob Evans and IHOP. (Exhibit A; Testimony.)

5. On February 5, 2019, the Department received from Petitioner, a request for Direct Member Reimbursement (DMR) for meals and lodging related to Petitioners stay at the [redacted] and [redacted] (Exhibit A; Testimony.)

6. On February 6, 2019, the Department sent Petitioner written notification indicating the DMR request was denied. The notice indicated the DMR request was not in accord with the Medicaid Provider Manual (MPM). Specifically, it indicated the DMR request was not the least expensive sufficiently maintained lodging available and that there were other meal and lodging accommodations that were closer to the provider and less expensive. (Exhibit A; Testimony.)

7. On August 2, 2019, the Department received from Petitioner an appeal request regarding the February 6, 2019 DMR determination. (Exhibit A; Testimony.)

8. On October 1, 2019, the Department sent Petitioner written notification indicating the February 6, 2019 DMR determination was being affirmed. (Exhibit A; Testimony.)

9. On October 22, 2019, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A.)

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.

Policy addressing medical transportation coverage under the MPM can be found in the Non-Emergency Medical Transportation Chapter.

Section 1 Introduction

This chapter applies to non-emergency medical transportation (NEMT) providers and authorizing parties. The Medicaid NEMT benefit is covered for Medicaid, MIChild, and Healthy Michigan Plan (HMP) beneficiaries, and for Children's Special Health Care Services (CSHCS) beneficiaries who also have Medicaid coverage.

Federal law at 42 CFR 431.53 requires Medicaid to **ensure necessary transportation for beneficiaries to and from services that Medicaid covers.** The NEMT benefit must be administered to beneficiaries in an equitable and consistent manner.

Section 3 Transportation Authorization

Medicaid authorizes fee-for-service (FFS) NEMT services via local MDHHS offices, except in Wayne, Oakland, and Macomb counties. FFS transportation services in Wayne, Oakland, and Macomb counties are administered through a contracted transportation broker. (Refer to the Directory Appendix for transportation broker information.)

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP/ICO for further information regarding NEMT. Transportation services for managed care enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

Section 5 Covered Services

NEMT expenses, regardless of whether ther is a corresponding medical claim on the date of service, may be covered for trips to and from:

- Treatment Medicaid covers (one-time or ongoing);
- Ancillary service providers (e.g., pharmacies, durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] providers) to obtain a service or item Medicaid covers;
- Medical care, treatment or services that have been prior authorized;
- Appointments to obtain medical evidence (for eligibility verification purposes only); and
- Facilities providing services Medicaid covers that do not charge for care.

Transportation from a service Medicaid covers is only covered when it is from the provider's location to the beneficiary's residence or to another service Medicaid covers. **The least costly mode of transportation appropriate for the beneficiary's medical needs must be used**.

Section 5.2 Meals

Authorized meals for beneficiaries, volunteer drivers, or individuals with a vested interest are reimbursed at cost or at the maximum allowable amount, whichever is less. To be entitled to meal reimbursement, one of the following must be met:

- For breakfast: The vehicle with the beneficiary must depart at, or before, 6:00 AM and must return at, or after, 8:30 AM.
- For lunch: The vehicle with the beneficiary must depart at, or before, 11:30 AM and must return at, or after, 2:00 PM.
- For dinner: The vehicle with beneficiary must depart at, or before, 6:30 PM and must return at, or after, 8:00 PM.

Meal reimbursement requires original, itemized, unaltered receipts which must include the business name, address, date, time, itemized list of items purchased with cost of each item. However, if the restaurant or place of business omits any necessary items form their receipt, the information may be hand-written by the individual incurring that expense.

Bulk purchases of groceries and shared meals are not reimbursable. Meals must be purchased and consumed on the day and within the time of travel. Reimbursement for alcoholic beverages is not permitted. If a lodging reservation or other travel includes a complimentary breakfast or other meals, Medicaid does not provide any additional reimbursement for that meal.

Section 5.4 Lodging

Medically necessary overnight stays which include meals and lodging may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or

> individual with a vested interest) for no more than five consecutive nights. Medically necessary overnight stays beyond five nights require prior authorization (PA) from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.)
>
> Medically necessary overnight stays which include meals and lodging at a Level IV Neonatal Intensive Care Unit (NICU) may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than 14 nights. Necessary overnight stays at a Level IV NICU beyond 14 nights require PA from PRD.
>
> Overnight stays which include meals and lodging ordered by a physician or required due to travel distance may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest). **The least expensive, sufficiently maintained lodging available must be utilized. The availability of nonprofit accommodations (i.e., Ronald McDonald House or accommodations available through the visiting medical facility) must be explored before commercial lodging is considered.** Lodging expenses are reimbursed at cost or the maximum allowable amount, whichever is less. Original, itemized, unaltered receipts are required. Reimbursement beyond an accommodation's suggested donation amount or per night rate as charged to the public will not be made.[1]

The Department argued the Petitioner's stay in [redacted] and the meals purchased there were not a Medicaid covered service and such were not reimbursable. Specifically, the Department argued that Petitioner had to utilize the least costly or least expensive and ensure the stay was medically necessary.

In this case, Petitioner was receiving treatment in Grand Rapids, Michigan. Grand Rapids, Michigan is the second largest metropolitan area in the state of Michigan. From there, Petitioner traveled approximately 90 miles northeast of Grand Rapids, Michigan to stay at the [redacted] and [redacted] in Mount Pleasant, Michigan.

Petitioner did not provide any evidence that they either sought out less costly and closer alternatives nor did they show evidence of them being denied less costly and closer alternatives.

Petitioner argued they were told they would be paid the maximum amount and they would pay the additional cost out of pocket. While this may be the case, Petitioner must still show that the stay was both medically necessary and that less costly accommodations were explored.

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[1] Medicaid Provider Manual, Non-Emergency Medical Transportation Chapter, January 1, 2019, pp 1, 4, 8-10.

Based on the evidence presented, I find it was not medically necessary for Petitioner to travel an additional 180 miles round trip to stay at the [redacted] and [redacted] while receiving treatment in Grand Rapids. Additionally, I do not find Petitioner to have sought out less costly alternatives.

Consequently, I find sufficient evidence to affirm the Department's decision to deny Petitioner's meals and lodging reimbursement request.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's request for meal and lodging reimbursement.

IT IS, THEREFORE, ORDERED that:

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

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact	Managed Care Plan Division CCC, 7th Floor Lansing, MI 48919
Counsel for Respondent	Jonathan F. Gruner McLaren Health Plan G-3245 Beecher Road Flint, MI 48532
Community Health Rep	McLaren Health Plan G 3245 Beecher Rd. Suite 200 Flint, MI 48532
Petitioner	[redacted] MI
Authorized Hearing Rep.	[redacted] MI