[redacted]
[redacted], MI [redacted]

Date Mailed: June 18, 2020
MOAHR Docket No.: 20-002436
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 upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 3, 2020. [redacted], Administrative Assistant at Community Medical Equipment, Inc., appeared and testified on Petitioner's behalf, with [redacted], Billing Coordinator at Community Medical Equipment, Inc., also present. Attorney Karen Mucha represented Aetna Better Health of Michigan, the Respondent Medicaid Health Plan (MHP). Dr. Talat Danish, Medical Director, testified as a witness for Respondent, with Sheila McIntyre, Grievance and Appeals Manager, and Jusus Yanaz, Grievance and Appeals Consultant, also present.

During the hearing, Respondent submitted a hearing summary and seven exhibits that were admitted into the record as Exhibits #1-#7. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for a pneumatic compression device?

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 is enrolled in the Respondent MHP. (Exhibit #4).

2. On February 11, 2020, Respondent received a prior authorization request submitted on Petitioner's behalf by her doctor for a pneumatic

compression device. (Exhibit #1).

3. The pneumatic compression device was to be provided by Community Medical Equipment, Inc. (Exhibit #1).

4. Community Medical Equipment, Inc. is not enrolled in Respondent's network of providers. (Testimony of Petitioner's representative; Testimony of Respondent's Medical Director).

5. On February 14, 2020, Respondent sent Petitioner written notice that the prior authorization request had been denied. (Exhibit #1).

6. The notice gave two reasons for the denial:

> 1. We do not have records that show that you have tried and did not get better using a compression device that does not use pressure (calibrated).
> 2. We do not cover services that are out-of-network. This includes services for out-of-network:
>
> - doctors
> - hospitals
> - companies
>
> The only time we cover out-of-network provider is:
>
> - in emergencies
> - if we don't have a doctor in our network close to you
> - to continue care you are already getting
>
> The doctor/hospital/provider is not part of our network. You can get the service needed from a provider in our network. We would be happy to help you find one of our providers. We made the decision using [Respondent] Prior Authorization Policy Number 7100.05 and [Respondent] Clinical Policy Bulletin 0482 Compression Garments for the legs.

Exhibit #1

7. On February 28, 2020, Petitioner filed an appeal with Respondent regarding the denial of the prior authorization request. (Exhibit #4).

8. On March 18, 2020, Respondent sent Petitioner written notice that Petitioner's appeal had been reviewed and that the denial was being upheld for the same reasons stated in the notice of denial. (Exhibit #1).

9. On April 20, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision.

CONCLUSIONS OF LAW

The Medical Assistance Program 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.

In 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 covered 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. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

MPM, January 1, 2020 version
Medicaid Health Plan Chapter, pages 1-2
(underline added for emphasis)

Moreover, regarding out-of-network services, the MPM also states:

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;
- Tuberculosis services; and
- Certain MIHP services (refer to the Maternal Infant Health Program Chapter for additional information).

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service.

2.6.B. HOSPITAL SERVICES

MHPs reimburse hospitals according to the terms of the contract between the MHP and the hospital. If a hospital does not have a contract with an MHP but has signed a hospital access agreement with MDHHS, the following conditions apply:

- The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid beneficiaries enrolled in MHPs with which the hospital does not have a contract.
- MHPs agree to continue to use network-contracted providers when available and appropriate.
- The hospital will be entitled to payment by MHPs for all covered and authorized (if required) services provided in accordance with their obligations under the agreement.
- A rapid dispute resolution process will be available for hospitals and MHPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- MHPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. The payment for inpatient stays includes the relevant DRG and capital costs.

Copies of the Hospital Access Agreement, Health Plan Obligations, and Rapid Dispute Resolution are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Hospitals that have signed the Hospital Access Agreement and the MHPs are required to abide by the terms and conditions of the Agreement.

2.6.C. POST-STABILIZATION AUTHORIZATION DETERMINATIONS

Non-contracted hospitals are required to obtain a patient post-stabilization authorization determination from the beneficiary's MHP prior to any treatment and after stabilization. A post-stabilization authorization determination refers to the process in which inpatient hospital admission or admission to observation status is authorized by the MHP after the beneficiary has been stabilized. (Note: This applies only to MHP beneficiaries who are not dually Medicare and Medicaid eligible. MHPs may not utilize prior authorization (PA) requirements for hospital services for dual Medicare

> and Medicaid eligible beneficiaries enrolled in an MHP and Medicare fee-for-service.) . . .
>
> *MPM, January 1, 2020 version*
> *Medicaid Health Plan Chapter, page 6*

Here, pursuant to the above policies and its contract with MDHHS, Respondent has limited coverage of non-emergency out-of-network services:

> **Out-of-network services**
> If [Petitioner] is unable to provide necessary medical services, covered under the contract, within the network of providers, [Respondent] will coordinate these services adequately and timely manner with out-of-network providers, for as long as the organization is unable to provide the services. [Respondent] will provide any necessary information for the Member to arrange the service. The Member will not incur any additional cost for seeking these services from an out-of-service provider.
>
> *Exhibit #3*

Here, Respondent denied the prior authorization request on the basis that requested device was not medically necessary and that the identified provider was outside of Respondent's network of providers.

Petitioner has the burden of proving by a preponderance of the evidence that Respondent erred in denying the prior authorization request. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the above policy and evidence in this case, Petitioner has not met her burden of proof and Respondent's decision must therefore be affirmed.

Petitioner's representative testified that, while Community Medical Equipment, Inc. is not enrolled in Respondent's network of providers, it is enrolled in Medicaid as a provider and it is the preferred provider of Petitioner's physician.

However, the mere fact that Community Medical Equipment, Inc. is the preferred provider of Petitioner's physician and enrolled in Medicaid does not establish that Respondent erred in this case. Respondent is permitted by both the MPM and its contract with MDHHS to limit coverage to providers within its network, with certain

exceptions; it has chosen to do so; and the record demonstrates that none of the listed exceptions apply in this case.[1]

Accordingly, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that Respondent's decision must 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 authorization request.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/sb

Steven Kibit
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

[1] Given the above findings, the undersigned Administrative Law Judge need not discuss Respondent's other grounds for denying Petitioner's request.

DHHS -Dept Contact

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CCC, 7th Floor
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Petitioner

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Authorized Hearing Rep.

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