[redacted]
MI [redacted]

Date Mailed: July 14, 2021
MOAHR Docket No.: 21-002385
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 17, 2021. [redacted] and [redacted] Petitioner's parents, appeared and testified on the minor Petitioner's behalf. Holly Johnson, Senior Appeals Coordinator, appeared and testified on behalf of Priority Health, the Respondent Medicaid Health Plan (MHP).

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-132. Petitioner did not submit any exhibits.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for an esophagogastroduodenoscopy (EGD)?

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 [redacted]year-old who has been diagnosed with eosinophilic esophagitis. (Exhibit A, page 15).

2. For her diagnosis, Petitioner received treatment from a Dr. Philip Putnam, who is located in Cincinnati, Ohio, through private insurance or Children's Special Health Care Services (CSHCS). (Exhibit A, page 15; Testimony of Petitioner's father).

3. Effective February 1, 2021, Petitioner enrolled in Medicaid and the

Respondent MHP. (Testimony of Petitioner's father; Testimony of Respondent's representative).

4. On April 6, 2021, Respondent received a prior authorization request submitted on Petitioner's behalf by Dr. Putnam for an EGD for Petitioner to be performed on April 9, 2021. (Exhibit A, pages 14-22).

5. Dr. Putnam is not a participating provider in Respondent's network and his practice is located in Cincinnati, Ohio. (Exhibit A, page 15).

6. As part of the request, he noted: "continuity of care – has seen this provider/this clinic since 2017 for this diagnosis". (Exhibit A, page 15).

7. The request was not marked as urgent. (Testimony of Respondent's representative).

8. On April 7, 2021, Petitioner's mother contacted Respondent with respect to reimbursement for meals and lodging during the upcoming trip to see Dr. Putnam. (Testimony of Petitioner's Mother; Testimony of Respondent's representative).

9. During that telephone call, the representative for Respondent indicated that she did not see any authorization for services with Dr. Putnam. (Testimony of Petitioner's Mother; Testimony of Respondent's representative).

10. On April 9, 2021, Dr. Putnam performed the EGD. (Testimony of Petitioner's Father).

11. On April 13, 2021, Respondent sent Petitioner written notice that the prior authorization request was denied. (Exhibit A, pages 24-25).

12. With respect to the reason for the denial, the notice stated:

> The Michigan Department of Health and Human Services (MDHHS) Medical Provider Manual, General Information for Providers Section 7 – Sanctioned, Borderland and Out of State/Beyond Borderland Providers, states; we will cover out of state providers when a hospital needs to treat you for an emergency condition that, if not treated immediately, could result in putting your health in serious danger or if the service is not available within Michigan. After medical director review of the information submitted to Priority Health, you do not have a medical condition that needs instant treatment

> and treatment is also available within the state of Michigan. Therefore, requested out of state esophagogastroduodenoscopy is denied.

Exhibit A, page 24

13. Petitioner then filed an Internal Appeal with Respondent. (Exhibit A, page 9).

14. On May 12, 2021, Respondent sent Petitioner written notice that her Internal Appeal was denied. (Exhibit A, pages 9-12).

15. With respect to the reason for the denial the notice stated:

> Your request was not approved. Your Internal Appeal was thoroughly considered. However, services with Non-Participating Providers are not a covered benefit when the standard of care for treatment of [Petitioner's] condition can be provided within the Priority Health Michigan Medicaid network. The Medicaid Provider Manual and the Certificate of Coverage require that you obtain services from Providers who are participating in the Priority Health Michigan Medicaid network, therefore we are unable to approve the request.
>
> The Appeal Committee noted your comments that, prior to seeking the requested services, you understood that Dr. Putnam and Cincinnati Children's Hospital were both Non-Participating Providers and you were obtaining services with these providers without the required prior authorization. Despite awareness of the lack of coverage, you elected direct care outside of the network. The Medicaid Certificate of Coverage and Provider Manual was applied appropriately as there is care available in plan for [Petitioner]. Additionally, all referrals to Non-Participating Providers must be approved in advance by Priority Health.

Exhibit A, page 10

16. On May 19, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit A, pages 6-11).

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, April 1, 2021 version

Medicaid Health Plan Chapter, page 1
(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, April 1, 2021 version*
> *Medicaid Health Plan Chapter, pages 6-7*

Pursuant to the above policies and its contract with MDHHS, Respondent has limited coverage of non-emergency out-of-network services to those approved beforehand by Respondent:

> **Section 2 Obtaining Covered Services**
>
> **A. Primary Care Provider (PCP)**
> Your PCP also refers you to and consults with Specialist Providers, Participating Providers, and Non-Participating Providers when necessary. All referrals to or services received from Non-Participating Providers (providers not listed in our Provider Directory) must be prior approved by us unless we tell you otherwise in this Certificate.
>
> A referral from your PCP is not sufficient for us to Cover services from a Non-Participating Provider. If you do not receive written approval from us prior to obtaining services from a Non-Participating Provider, you may be responsible for payment. A copy of the Priority Health Choice, Inc. Provider Directory is available by calling our Customer Service department or online at priorityhealth.com.
>
> * * *
>
> **C. Referrals**
> At times you may need services from another Participating Provider, including a Specialist Provider, or a Non-Participating Provider. Participating Providers are those listed in the Priority Health Choice, Inc. Provider Directory. A Non-Participating Provider is one not listed in the directory.
>
> * * *
>
> Except for family planning services, FQHCs, Tribal Health Centers, local health departments and child and adolescent health centers, all referrals to a Non-Participating Provider must be prior-approved by us unless we tell you otherwise in

this Certificate. Referral by your PCP is not sufficient for Coverage of services received from a Non-Participating Provider. Do not go to another provider unless your PCP has referred you and we have approved the referral first.

* * *

31. Non-Participating Providers are providers who are not listed in our Provider Directory. For the most up-to-date directory, call our Customer Service Department or visit us at **priorityhealth.com.** Services and supplies from providers who have not contracted with us to provide services and supplies under this Certificate are not Covered except in the case of:

a. Medical Emergency or if approved by us in writing prior to obtaining the services and supplies.

*** * ***

48. Unauthorized Services and Supplies
The following are excluded unless we tell you otherwise in this Certificate:

* * *

b. Services and supplies that were provided without any required advance approval by us.

Exhibit A, pages 78-79, 91, 94-95, 97

Here, Respondent denied the prior authorization request on the basis that the identified provider was outside of Respondent's network of providers while the requested service was available in-network.

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.

It is undisputed that Dr. Putnam is a non-participating provider and, as such, any non-emergency services through him would have to be approved by Respondent prior to be

provided. Moreover, such approval would only be granted in circumstances where the requested service is not available within Respondent's network of providers.

Here, the requested EGD was not an emergency and, as credibly and fully explained by Respondent, it is a routine procedure that could have been provided by doctors who participate with Respondent. Moreover, nothing in the documentation submitted to Respondent suggested that the EGD was of such a nature that it could not be provided as a routine service by providers within Respondent's network.

Rather than suggesting that the EGD could not be provided in Michigan by doctors within Respondent's network, the prior authorization request only noted that Dr. Putnam had been providing services to Petitioner for years and that the request was based on a desire for continuity of care with the same doctor. However, while understandable, that preference to continue services with the same doctor does not warrant an approval of the prior authorization in this case on its own.

Petitioner's parents did testify that, years ago, they attempted to get care for Petitioner in the State of Michigan and that it was doctors in Michigan, including doctors who participate as providers in Respondent's network, who specifically referred Petitioner to Dr. Putnam. They also questioned why they would have to go through the same steps again. However, the record does not include any documentation or information about past referrals; the referral was not through Respondent as Petitioner was only recently enrolled with Respondent; and Respondent is permitted to require a need for the out-of-network of services prior to approving them.

Petitioner's parents also note that the past services through Dr. Putnam were approved through CSHCS. However, CSHCS is a separate program from Medicaid[1] and any past decision it made, which is not included in the record regardless, is not dispositive in this case.

Similarly, to the extent Petitioner's parents suggested that they did not know they had to get a prior approval from Respondent separate from CSHCS before the services would be covered, their testimony is likewise unpersuasive. They knew Petitioner was recently enrolled in Medicaid and with Respondent; they and Petitioner's doctor tried to get that prior approval and a request was submitted to Respondent; and Petitioner's mother was specifically advised that the required authorization was not in Petitioner's file when she called about reimbursement for meals and lodging. The appointment was scheduled and, given when the non-urgent prior authorization was submitted, waiting for a decision from Respondent may have necessitated rescheduling, but the record demonstrates that Petitioner's parents and doctor were aware of the need for prior authorization and chose to go forward with the procedure without it.

[1] *See* MPM, CSHCS Chapter, page 1.

Accordingly, for the reasons discussed above, 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

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
MDHHS-MCPD@michigan.gov

Petitioner

[redacted], MI

Community Health Rep

Priority Health Choice
Kellie McCowan
Holly Johnson
1231E. Beltline NE
Grand Rapids, MI
49525-4501
Holly.Johnson@priorityhealth.com

Authorized Hearing Rep.

[redacted] MI