[redacted], MI [redacted]

Date Mailed: April 5, 2022
MOAHR Docket No.: 22-000659
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 March 24, 2022. Petitioner appeared and testified on her own behalf. Lisa Johnson, Appeals and Grievance Lead, appeared and testified on behalf of Molina Healthcare of Michigan, the Respondent Medicaid Health Plan (MHP). Dr. Keith Tarter, Senior Medical Director, also testified as a witness for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-53. No other proposed exhibits were submitted.

ISSUE

Did Respondent properly deny Petitioner's request for physical therapy 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 [redacted] year-old Medicaid beneficiary enrolled in the Respondent MHP and who has been diagnosed with right shoulder pain, low back pain, weakness, and balance deficits after being diagnosed with COVID-19. (Exhibit A, pages 25, 27).

2. In March of 2021, Petitioner was approved by Respondent for physical therapy services at Mary Free Bed Rehabilitation. (Testimony of Petitioner).

3. Petitioner received those services through May of 2021. (Testimony of Petitioner).

4. On June 15, 2021, Respondent received a request for physical therapy

services submitted on Petitioner's behalf for the period of June 15, 2021 to July 28, 2021. (Exhibit A, pages 24-34).

5. The physical therapy was again to be provided at Mary Free Bed, but the National Provider Identifier (NPI) number used for the facility was now for a provider not in Respondent's network of providers. (Exhibit A, page 25; Testimony of Senior Medical Director).

6. On June 24, 2021, Respondent sent Petitioner written notice that the request had been denied. (Exhibit A, pages 38-47).

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

> The notes sent in show that you have a shoulder and back condition. A request was received for physical therapy. The provider is out of network. This does not meet criteria for out of network provider services. This service is available by network providers in your area. The notes do not show a medical need that cannot be met by a provider from the network. Therefore, the request for out of network provider services is denied.
>
> Criteria used: Molina Healthcare's Member Handbook, Guidance of Coverage, Appendix A 29, Out of Network Services
>
> A Molina Healthcare of Michigan Medical Director, Dental Director or Clinical Pharmacist is available to discuss the denial decision with any treating practitioner.

Exhibit A, page 38

8. On June 29, 2021, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 6).

9. On July 1, 2021, Respondent sent Petitioner written notice that her Internal Appeal had been denied. (Exhibit A, pages 10-22).

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

> - This does not meet Molina Healthcare's Member Handbook, Guidance of Coverage, Appendix A-29, Out-of-Network Services criteria.
>
> - This Service is available by a PAR provider in the member's area.
>
> - There is no documentation of a medical need that cannot be met by a PAR provider.

Exhibit A, page 6

11. On February 14, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter. (Exhibit A, pages 5-8).[1]

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) in effect at the time of the services at issue in this case, 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

[1] The Internal Appeal decision was dated July 1, 2021, while Petitioner's request for hearing was not received until February 14, 2022, which suggests that Petitioner's request was untimely and that MOAHR therefore lacks jurisdiction. *See* 42 CFR 438.408(f)(2). However, Respondent did not move for dismissal on that basis and Petitioner's request for hearing was dated August 1, 2021, and the undersigned Administrative Law Judge therefore determined on the record that he would not dismiss the case due to untimeliness and a lack of jurisdiction.

> 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*

As allowed by the above policy and its contract with the Department, Respondent has developed prior authorization requirements and specific utilization, management, and review criteria.

Moreover, with respect to the out-of-network services like the ones requested by Petitioner, that review criteria states in part:

> **4. Out-of-Network Services.** Services provided by out-of-network providers are covered if medically necessary, authorized by the Plan, and could not reasonably be obtained by a network provider, inside or outside of the State of Michigan, on a timely basis.
>
> *Exhibit A, page 51*

Respondent's policy is consistent with the applicable published Medicaid coverage and limitation policies for out-of-network services set forth in the MPM:

> **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.
>
> *MPM, April 1, 2021 version*
> *Medicaid Health Plan Chapter, page 6*

Here, Respondent denied the submitted prior authorization request pursuant to the above policies and on the basis that the services were to be performed by a provider outside of Respondent's network of providers even though the services are available in-network.

In support of that decision, Respondent's Senior Medical Director testified that Respondent has limited coverage of non-emergency out-of-network services to those that cannot reasonably be obtained by a network provider on a timely basis. He also

testified that the physical therapy services requested in this case are available through multiple in-network providers, while also citing to a list of such providers located within ten miles of Petitioner's city.

In response, Petitioner testified that she was previously approved by Respondent for physical therapy services through the same provider in March of 2021; she received the services through May of 2021; the services are still needed; and she does not know why the new request was denied.

Respondent's Senior Medical Director then testified that Respondent has a contract with the Mary Free Bed Rehabilitation, where the requested physical therapy services were to be provided, but that the specific NPI number used on the prior authorization request in this case was for a provider who is not within Respondent's network. He also testified that physical therapists with Mary Free Bed Rehabilitation were not listed in Respondent's exhibit because they are farther away from Petitioner's city, but that there are such therapists who are also in Respondent's network.

Petitioner then testified that she has been going to the same location for the services. She could not address what NPI number was used on the prior authorization request or why, but further testified that she was directed to go to Mary Free Bed Rehabilitation by her doctor. She also agreed that Mary Free Bed Rehabilitation has a number of physical therapists within it and multiple locations.

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 failed to meet her burden of proof and Respondent's decision must therefore be affirmed.

Consistent with the above policies and its contract with MDHHS, Respondent has limited coverage of non-emergency out-of-network services to those that cannot reasonably be obtained by a network provider on a timely basis; and Petitioner cannot demonstrate that the requested physical therapy services in this case cannot be obtained within Respondent's network, with nothing in the record indicating anything atypical about the services and Respondent providing a list of in-network providers who could provide them.

Moreover, while Petitioner testified that she was previously approved for the requested services at the same provider, she acknowledged that Mary Free Bed Rehabilitation has multiple locations; she does not dispute that the NPI used in the specific prior authorization request in this case was for a non-network provider; and she does not dispute that in-network providers are available.

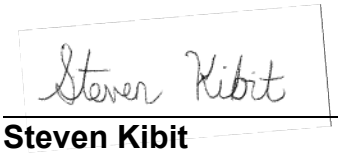
Accordingly, while the physical therapy services may be medically necessary and the denial in this case based on an error in the information provided as part of the prior authorization request, Respondent's decision must be affirmed given the available information and applicable policy. To the extent Petitioner wants physical therapy services through an in-network provider, she and the provider can always submit a new authorization request.

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 out-of-network physical therapy services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**



SK/tem

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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 [redacted]

Community Health Rep

Molina Healthcare of Michigan
Chasty Lay
880 W. Long Lake Rd., Suite 600
Troy, MI 48098
Chasty.Lay@MolinaHealthCare.com