[redacted]
[redacted] MI [redacted]

Date Mailed: May 23, 2023
MOAHR Docket No.: 23-002167
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 May 17, 2023. Petitioner [redacted] (Petitioner) appeared and testified on her own behalf. Bryan Keith, Manager of Grievances, appeared and testified on behalf of Meridian, the Respondent Medicaid Health Plan (MHP or Respondent).

During the hearing, Petitioner's Request for Hearing was admitted as Exhibit #1, pages 1-6.

ISSUE

Did Respondent properly deny Petitioner's request for reimbursement 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 Medicaid beneficiary enrolled with Respondent. (Testimony of Petitioner; Testimony of Manager of Grievances).

2. On [redacted] 2023, Petitioner received dental services provided by Grand Traverse Oral Surgery. (Exhibit #1, page 1).

3. Grand Traverse Oral Surgery is neither within Respondent's network of providers nor enrolled as a Medicaid provider. (Testimony of Petitioner; Testimony of Manager of Grievances).

4. Grand Traverse Oral Surgery also never sought prior authorization for the services that it performed. (Testimony of Petitioner; Testimony of Manager of Grievances).

5. Petitioner paid $915.00 for the services. (Exhibit #1, page 5).

6. She then submitted a claim for reimbursement from DentaQuest, Respondent's dental vendor. (Testimony of Petitioner; Testimony of Manager of Grievances).

7. DentaQuest denied the claim for reimbursement. (Testimony of Petitioner; Testimony of Manager of Grievances).

8. On February 6, 2023, Petitioner filed a grievance/Internal Appeal with Respondent regarding that denial. (Exhibit #1, page 2; Testimony of Manager of Grievances).

9. On March 31, 2023, Respondent sent Petitioner a written notice stating that her grievance/Internal Appeal was denied. (Exhibit #1, page 1).

10. With respect to the reason for its decision, Respondent stated in part:

> We sent your concerns to DentaQuest. They reviewed your account. DentaQuest sent the Plan the claim for your date of service (DOS) 2/6/2023. The service was denied. The service D9999 was denied as it not [sic] a covered benefit. Your services were performed by an out of network provider. The Plan does not cover out of network benefits. We are sorry for any inconvenience. If you have any benefit questions, please call Member Services.
>
> * * *
>
> If this grievance is relating to a medical service that Meridian denied, you may ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) if you are not happy with the action taken. You can ask for this at any time in the next 120 days.
>
> *Exhibit #1, page 1*

11. On April 19, 2023, the Michigan Office of Administrative Hearings and Rules received the request for hearing filed by Petitioner. (Exhibit #1, pages 1-6).

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 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, 2023 version*
> *Medicaid Health Plan Chapter, page 1*

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

> **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, January 1, 2023 version*
> *Medicaid Health Plan Chapter, page 6*

Here, Respondent denied Petitioner's request for reimbursement pursuant to the above policies and on the basis that the services were performed by a provider outside of Respondent's network of providers.

In appealing that decision, Petitioner has the burden of proving by a preponderance of the evidence that Respondent erred. 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 record 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 requires out-of-network providers to obtain plan authorization prior to providing services to plan enrollees; none of the exceptions to that policy apply in this case; and no prior authorization was sought or approved before the services in question were provided. Moreover, while Petitioner testified that there were no providers within Respondent's network that could provide the medically necessary services, her testimony is unsupported and that is a dispute to be resolved prior to the services being provided.[1]

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 reimbursement for out-of-network services.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED.**

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

[1] Petitioner testified that the out-of-network provider refused to submit a prior authorization request. However, even if true, Petitioner still elected to proceed without the prior authorization and any dispute over the billing is between her and her provider.

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last-known addresses in the manner specified below, this 23rd day of May 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

Petitioner
[redacted]
[redacted] MI [redacted]
[redacted]

Community Health Representative
Katie Feher
Meridian Health Plan of Michigan Inc.
Detroit, MI 48244
Katie.feher@centene.com

DHHS Department Contact
MDHHS
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