BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS
ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	
J C	)	OAH No. 13-0075-MDS
	)	HCS Case No.
	)	Medicaid ID No.

DECISION

I. Introduction

The issue in this case is whether the Division of Health Care Services (Division) was correct to deny a request for prior authorization of behavioral health services for Mr. C. The Division denied the request for prior authorization on the ground that Mr. C had not been found eligible for Medicaid (*i.e.* was not a current Medicaid recipient / participant) as of the date of the Division's denial. The hearing testimony confirms that Mr. C in fact was not a Medicaid recipient from the date of the prior authorization request through the date the Division denied that request. Medicaid coverage is available only to Medicaid recipients. Because Mr. C was not a Medicaid recipient during the period in question, the Division was correct to deny his clinician's prior authorization request. The Division's decision denying Mr. C's prior authorization request is therefore affirmed.

II. Facts

The relevant facts in this case are not in dispute. Mr. C was a Medicaid recipient from August 2005 through December 2010.[1] On October 3, 2012 S Q, M.S., completed and signed a prior authorization request for behavioral health services on behalf of Mr. C.[2] The request for prior authorization was submitted to Xerox State Healthcare, LLC (Xerox) on December 5, 2012.[3] The request sought approval for Medicaid payment for certain clinical and rehabilitative services for Mr. C.[4] On December 21, 2012 Xerox notified Mr. C that it had denied his clinician's prior authorization request.[5] The denial letter stated in relevant part: [6]

> Based on the information provided . . . the request is denied for the following reasons, based on the following legal authority:

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1 Exs. E1, E6.
2 Exs. E3 - E5.
3 Exs. D1, E1. Xerox reviews requests for prior authorization under a contract with the Department of Health and Social Services (DHSS) (Ex. D1).
4 Exs. E3, E4.
5 Ex. D1.
6 Ex. D1.

> Medicaid covered services are available only to currently eligible Medicaid / Denali KidCare recipients. Your eligibility for State of Alaska Medicaid benefits ended on 12/31/10. 7 AAC 105.100(2).
> . . . .
> Please note: If the request for service was denied due to eligibility status and your eligibility status changes, please contact the rendering provider for resubmission or subsequent review.

Mr. C requested a hearing to contest the Division's decision.[7] Mr. C's hearing was held on March 11, 2013. Mr. C represented himself. He and his case manager, D H, attended in person and testified. Medical Assistance Administrator Gerry Johnson represented the Division by phone, and testified on its behalf. The record closed at the end of the hearing.

III. Discussion

Mr. C does not dispute that he had not applied and been found eligible for Medicaid prior to the date the Division denied the prior authorization request at issue. Accordingly, the only issue is the purely legal issue of whether an individual must apply and be found eligible for Medicaid as a prerequisite to obtaining prior authorization for Medicaid services.

The regulation relied on by the Division, Alaska Medicaid regulation 7 AAC 105.100, states in relevant part that "[t]he department will pay for a [Medicaid] service only if that service . . . (2) is provided to an individual who is eligible for Medicaid under 7 AAC 100 on the date of service . . . ." Construed in isolation, this regulation could be interpreted *either* as requiring a determination of eligibility as a prerequisite to prior authorization of Medicaid services, *or* as requiring only that a person meet all eligibility requirements, allowing an express determination of eligibility to be made at a later date. However, construed in the context of other relevant Medicaid regulations, it is clear that 7 AAC 105.100(2) requires that the Division expressly determine that a person is eligible for Medicaid before prior authorization for particular services can be authorized.

For example, 7 AAC 100.001 provides in relevant part that, "[t]o be eligible for Medicaid coverage . . . an individual must qualify under this chapter in an eligibility category listed in 7 AAC 100.002." Similarly, 7 AAC 100.004(a) provides in relevant part that "[t]he department will not act on a request for Medicaid eligibility or coverage until the department receives an identifiable application . . . . on a form provided by the department for the purpose of applying for Medicaid." Likewise, 7 AAC 100.012(a) provides in relevant part that "[t]he department will make a finding of eligibility or ineligibility for every identifiable application for Medicaid . . . ." Again, 7 AAC

[7] Ex. C.

100.008(a) requires the filing of a "new application" for Medicaid "if, at the time of application, the individual is not receiving Medicaid . . . ." Finally, 7 AAC 160.990(69) defines the term "recipient" as "an individual who has been determined eligible for Medicaid in this state, including home and community-based waiver services, and who is receiving, is authorized to receive, or has received a Medicaid-covered service from a provider enrolled in the Medicaid program in this state." Construing these regulations together, it is clear that a person must actually submit an application, and be determined eligible for Medicaid, before a service authorization request may be granted.

There is one exception to this rule. Under 7 AAC 100.072(a), "[a]t the time of application or interview, an applicant may request Medicaid coverage for a maximum of three months immediately preceding the month of application if the applicant has unpaid medical expenses for dates of service any time during that three-month period."[8] Mr. C stated at hearing that he had applied for Medicaid following the Division's December 2012 denial of his prior authorization request. However, Mr. C has not claimed that he has requested retroactive coverage, or that he is entitled to retroactive coverage for the services at issue.[9] Accordingly, retroactive coverage is not at issue in this case.[10]

IV. Conclusion

The Division did not dispute that Mr. C has a need for the medical services he seeks. However, the Division's regulations prohibit prior authorization of Medicaid services for persons not previously determined eligible for Medicaid. It is undisputed that Mr. C had not been determined eligible for Medicaid at the time of his clinician's prior authorization request or at the time the Division denied that request. Accordingly, the Division was correct to deny Mr. C's request for prior authorization, and the Division's decision is therefore affirmed.

Dated this 14th day of March, 2013.

Signed
Jay Durych
Administrative Law Judge

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[8] *See also* 7 AAC 105.130(d).

[9] Were Mr. C to timely request retroactive coverage, and were the Division to deny that request, then Mr. C would be entitled to request a hearing on that issue (as long as his hearing request was timely filed).

[10] The Division asserted at hearing that, even had Mr. C requested retroactive Medicaid coverage for the services at issue, he would not be entitled to retroactive coverage because 7 AAC 135.010 and 7 AAC 135.040 prohibit retroactive coverage for behavioral health services. However, because Mr. C has not asserted that he is eligible for retroactive coverage, it is not necessary to address that issue in this decision.

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 28th day of March, 2013.

By: *Signed*
Name: Jay D. Durych
Title: Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]