STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-14470 QHP
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on his own behalf.

Representing [redacted] was [redacted]. and [redacted]

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for lumbar epidural steroid injections?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (hereafter, 'MHP'). He suffers from chronic mid and low back pain and has a diagnosis of lumbar radiculopathy. *(Exhibit 1, p. 3)*

2. On [redacted], the MHP received a faxed request from [redacted] for referral to [redacted] for lumbar epidural steroid injections. The MHP denied the request on [redacted]. The denial is based on medical documentation which indicated the Appellant participated in one documented physical therapy visit, that he was then "laid up for 3 days" secondary to pain, that he cancelled all further physical therapy

appointments, and that he therefore failed to produce evidence that physical therapy did not alleviate his pain symptoms.

3. On [redacted], the MHP issued denial letters to the Appellant and his physicians.

4. An [redacted], physical therapy "missed visit report" compiled by [redacted] indicates the Appellant's physician has placed him on "hold" with regard to future physical therapy treatment. *(Exhibit 2).*

5. A [redacted] physician progress note contains the following comments under "Medical Decision Making:" *"(1) lumbar pain—neural and foraminal stenosis…failure of PT—pt unable to tolerate; L4-L5 facet injections recommended by neurosurgery." "…"* *(Exhibit 1, p. 5)*

6. A [redacted] physician progress note contains the following comments under "History of Present Illness." *"…seen @ PT x 1, then 'laid up X 3 days; patient cancelled further appointments---had 10/11 pain."* *(Exhibit 1, p. 5)*

7. On [redacted] the Appellant underwent a Magnetic Resonance Imaging of the lower spine without contrast. It provides, in pertinent part, as follows:

> *"…At the L4/5 level there is a mild broad-based disc bulge. There is moderate to marked hypertrophic facet disease. This is causing some pressure effect on the thecal sac and narrowing the AP dimension of the thecal sac to about 9 mm representing a borderline to mild acquired stenosis. There is mild bilateral neural foraminal narrowing at this level as well. The hypertrophic facet disease is seen throughout the lumbar spine. No other disc bulges or disc herniations or neural foraminal are noted."* *(Exhibit 1, p. 6)*

8. A [redacted] Neurosurgical Consultation contains the following comment(s) under "Diagnostic Studies:" *[redacted] reviewed the patient's MRI which does demonstrate central and bilateral foraminal stenosis at L4-5 as a result of degenerative changes and facet hypertrophy."* *(Exhibit 1, p. 8)*

9. On [redacted] the Appellant submitted his Request for Hearing to the State Office of Administrative Hearings and Rules for the Department of Community Health.

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.

On May 30, 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.

Midwest Health Plan is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverage(s) and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
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> Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.
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> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
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> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

- An annual review and reporting of utilization review activities and outcomes/interventions from the review.

The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverage(s) established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, September 30, 2004.

The MHP's denial in this case is based on its conclusion that the Appellant's single physical therapy visit is insufficient to determine whether this mode of treatment may address, and improve his chronic pain symptoms.

Bilateral facet joint injections (nerve blocks) are a Medicaid covered service, given the following criteria:

4.16 NERVE BLOCKS

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

> Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area are covered within a six-month period without documentation of medical necessity. Documentation must include the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.
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A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

The MHP testified it denied the Appellant's request for facet joint injections because he only attended one physical therapy appointment, and therefore failed to meet MHP criterion for this procedure. The MHP contends its policy requires evidence that a beneficiary has participated in 6 months of physical therapy.

Under its contract with the Department an MHP is permitted to establish medical necessity criteria, but prohibited from imposing criterion on its members that fee-for-service beneficiaries would not otherwise have to satisfy.

The MHP requires 6 months of physical therapy. To the contrary, fee-for-service Medicaid beneficiaries are not subjected to this requirement. Fee-for-service beneficiaries need only provide medical documentation, including the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. Fee-for-service beneficiaries are not required to participate in 6 months of physical therapy before this procedure would be covered.

I specifically conclude the MHP's criteria regarding nerve blocks conflicts with clearly articulated Medicaid Provider Manual criteria that provide coverage for this procedure. I must therefore conclude it is being applied in this case to deny an otherwise medically necessary service.

A review of the medical evidence presented supports a conclusion that the Appellant's physician directed him to refrain from participating in any further physical therapy. The MHP appears to imply the Appellant unilaterally decided to stop attending physical therapy. The Appellant credibly testified this is not the case, and that, because he cannot physically tolerate physical therapy, his physician instructed him to cease participation.

The MHP also contends the Appellant has not demonstrated he "failed" physical therapy. A review of medical documentation clearly indicates the Appellant's physician(s) document he cannot tolerate physical therapy, and with this conclusion, recommend facet joint injections.

Based on a preponderance of the evidence presented, I conclude the MHP has improperly denied the Appellant's request for facet joint (nerve block) injections, which, according to a preponderance of the evidence presented, is a Medicaid-covered, medically necessary service.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Appellant has established, by a preponderance of the evidence presented, that the MHP improperly denied his request for facet joint injections.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/13/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.