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. 2009-35889 QHP
Case 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]

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 is diagnosed with chronic neck and back pain. *(Exhibit 1, p. 9)*

2. On [redacted], the MHP received a faxed request from [redacted] at [redacted] for the approval of lumbar epidural steroid injections. Attached to the request was a previous denial letter from [redacted], for the same service. In that letter, the MHP indicates that physical therapy must be attempted for at least 6 months before injections can be approved, and that the record submitted at that time reflected a record of one physical therapy visit.

3. The [redacted], request reflects that physical therapy commenced on [redacted] On [redacted] it was documented that the Appellant underwent 13 physical therapy treatments and has experienced good tolerance to them. The [redacted], documentation also reflects that the Appellant has progressed well secondary to back pain but will now focus therapy on bilateral knee strengthening and improved balance. The [redacted] Progress Report also contains the following comments:

> *"…Patient reports his back is not really bothering him. Now, it is his knees that are much more painful, left greater than right. Patient states his knees are swollen throughout the day in that his left knee often feels like it wants to give out on him. The patient reports that his most recent fall was about 2 ½ weeks ago when he was going up steps." "…Patient is finding that it takes him about 2 hours to do the dishes because he requires so many breaks. Patient is also waking up at night about 1-2 times a week due to pain in his knees. Patient also says that it is painful to go up and down stairs and he uses a non-reciprocal gait pattern with 2 handrails. Patient is also using a single-point cane for ambulation and finds that walking on uneven ground is difficult. Patient is using a TENS unit and medications to help keep knee pain down in both knees."*
>
> *(Exhibit 1; pp. 7-8)*

4. 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.

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

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).

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).

The MHP's denial in this case is essentially based on its conclusion that the Appellant has not established epidural steroid injections to be medically necessary. In support of this assertion, the MHP notes that the Appellant has not participated in six months of physical therapy, and that the [redacted] progress notes accompanying the requested service note improvement for the period in which he has in fact participated in 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. An MHP is also permitted to provide increased coverage for its members.

The MHP requires 6 months of physical therapy in order to establish a minimal measure of medical necessity for epidural steroid injections. The Medicaid Provider Manual (MPM) does not specifically include epidural steroid injections as a covered service. Nerve blocks are a covered service under the MPM; however, nerve blocks and epidural steroid injections are, as the MHP aptly notes, different procedures.

Accordingly, I conclude the MPM covers nerve blocks, but not epidural steroid injections.

The progress notes clearly indicate the Appellant's back is not bothering him, but rather, that he is experiencing knee pain. The progress notes also indicate the Appellant has participated in 13 treatments, not the required six months. The specific service requested is lumbar (lower back) epidural steroid injections.

Because the medical evidence clearly supports a conclusion that the Appellant's back is not bothering him, I conclude the MHP has properly denied the Appellant's request for lumbar epidural steroid injections.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Appellant has failed to establish, by a preponderance of the evidence presented, that the MHP improperly denied his request for lumbar epidural steroid injections.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 12/1/2009

***** 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.