STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-1507 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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] [redacted] appeared on her own behalf.

Health Plan of Michigan was represented by [redacted], Director of Member Services. The witnesses for the health plan were [redacted], Manager Clinical Review Services, [redacted], Medical Director and [redacted], Medical Director. [redacted] is a Department of Community Health contracted Medicaid Health Plan (hereinafter MHP or Department).

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for Arthrodeses, anterior interbody technique, cervical fusion (neck surgery)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. The Appellant's medical conditions include cervical radiculopathy resulting in severe neck, shoulder and arm pain.

3. The MHP received a prior authorization request for Arthrodeses, anterior interbody technique, cervical fusion (neck surgery). Clinical documentation was submitted from [redacted] and the Appellant's primary care physician. (Exhibit 1 pages 12-56)

4. On [redacted] the MHP sent the Appellant an Adequate Action Notice stating that the request for Arthrodeses, anterior interbody technique, cervical fusion (neck surgery) was not authorized because the submitted clinical documentation did not support the medical criteria for the procedure. (Exhibit 1 pages 9-10)

5. The Appellant appealed the denial on [redacted].

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.

The Respondent 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 coverages 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.
>
> *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:
>
> - 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 coverages 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.*

Cervical fusion surgery falls within Medicaid Provider Manual policy governing general surgery. Section 12 General Surgery states "Medicaid covers medically necessary surgical procedures." *Michigan Department of Community Health Medicaid Provider Manual; Practitioner Version Date: October 1, 2009, Page 60.*

The Appellant has a long history of severe pain in her neck, shoulder and arm. She had a pervious cervical fusion about 6 years ago and an inferior fusion in [redacted] (Exhibit 1 page 12) The Appellant has extensive list allergies including medications, topical preparations, adhesive tape and latex. (Exhibit 1 page 18) The Appellant indicated that her allergies have limited some of the available conservative treatments options.

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. The MHP witnesses testified that the criteria used for considering cervical fusion surgery was consistent with Medicaid policy. The MHP said it based its decision on medical necessity and that was consistent with Medicaid policy.

The above contract language also says an MHP must conform to managed health care industry standards and processes and its utilization management decisions must be made by a health care professional who has appropriate clinical expertise regarding the service under review. The MHP physician reviewers have appropriate clinical expertise for surgical procedures regarding the Appellant. The MHP submitted the InterQual Procedures Criteria for Fusion, Cervical Spine and the MHP witnesses testified the guidelines are industry standards for cervical fusion surgery and are used by the MHP to determine medical necessity. (Exhibit 1, pages 65-66). The MHP witnesses testified that the InterQual Procedures Criteria were applied to the medical documentation from the Appellant's physicians and it was determined that the Appellant did not meet the InterQual criteria or medical necessity.

Specifically the MHP stated that the Appellant's most recent MRI, dated [redacted] does not reveal spinal stenosis, spinal cord compression, nerve root compression or an increase in the disc herniation at [redacted]. In fact, this MRI report indicates that the prior disc hernaition a [redacted] appears to have spontaneously reduced to mere bulging now and no cord compression, spinal stenosis, or new disc herniation is seen. (Exhibit 1, page 13). The MHP noted there were no fractures or subluxations noted on the imaging. Additionally the MHP stated that no myelopathic findings (pain, stiffness, numbness) were noted and that the clinical information provided did not include a physical examination from the surgeon documenting findings and recommendations. (Exhibit 1 pg. 9)

Upon the filing of the appeal in this matter, the MHP sent the Appellant's clinical documentation for an outside review by another physician reviewer who is certified in Neurological Surgery. This physician reviewer also concluded that the requested surgery was not warranted based on the documentation submitted noting that no detailed neurological or physical examination was included. (Exhibit 1 pages 57-62)

The MHP made their determination based upon the submitted clinical documentation. As noted above, the most recent MRI report showed spontaneous improvement at [redacted]. The Appellant testified that her pain, numbness and severely reduced range of motion have remained the same. The Appellant noted she has tried pain medications, injections, and physical therapy, all of which have failed to significantly improve her condition. However, the clinical documentation submitted to the MHP does not document these attempts in significant detail. For example, the Appellant testified that she received multiple injections which were not helpful. The clinical documentation submitted only includes only one procedure report for a cervical epidural injection. (Exhibit 1 pg. 17) There is no further documentation to show the effect of this injection or that the Appellant received any subsequent injections.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See 42 CFR 440.230.* Medical necessity can not be established in Appellant's case without complete documentation of the unsuccessful attempts to treat claimant's pain, detailed physical exam findings, complete documentation of claimant's

symptoms, or any additional imaging results. Without medical additional supporting documentation from the Appellant's physicians, the MHP properly denied the request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for Arthrodeses, anterior interbody technique, cervical fusion (neck surgery).

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/22/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.