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

Docket No. 2010-17497 QHP

[redacted]

Appellant
_____/

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] mother, appeared on Appellant's behalf. [redacted], [redacted], appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for cervical spine C4-C5 fusion 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. Appellant is a Medicaid beneficiary enrolled in [redacted] and [redacted] in the [redacted], a Medicaid Health Plan (MHP).

2. The Appellant is a [redacted] year-old female with a history of auto accident and fusion of cervical spine vertebrae C5-C7. (Exhibit 1, page 10).

3. On [redacted] the MHP received the Appellant's request for cervical spine fusion surgery [C4-C5] from Appellant's cervical spine fusion surgeon. (Exhibit 1, pages 8-17).

4. On or after [redacted], the MHP forwarded all medical documentation to an external, independent medical reviewer, board certified in neurological surgery. (Exhibit 1, pages 18-22).

5. On [redacted] the board certified neurological surgeon issued a report in which he found that the requested surgery was not appropriate because the symptoms did not correlate with the portions of the cervical spine at issue, and because other neurological conditions had not been investigated, and less conservative methods had not been investigated. (Exhibit 1, pages 18-21).

6. On [redacted] the MHP sent a letter to the Appellant stating that the request for cervical spine fusion surgery was denied because she did not meet medical necessity coverage criteria. The MHP letter stated that Appellant's symptoms were inconsistent with the portion of spine targeted for surgery and she had not provided documentation of trial and failure of conservative non-surgical methods. (Exhibit 1, pages 22-23).

7. On [redacted] the Appellant submitted a Request for Administrative Hearing. (Exhibit 1, page 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.

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 I-Z.

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, Final FY 2008 Contract, p. 32.

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 utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.

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, MDCH Contract, Final FY 2008 Contract, p. 66.

MHP Witness [redacted] indicated that the MHP cervical spine fusion surgery policy is consistent with Medicaid policy. Witness [redacted] explained that its criteria for coverage of cervical spine fusion surgery is limited to that which is medically necessary and appropriate. MHP witness [redacted] explained that the medical documentation submitted for Appellant raised a question about medical necessity and appropriateness. [redacted] explained that the request for cervical spine fusion surgery was forwarded to an external board certified neurological surgeon who issued a report in which he found that the requested surgery was not appropriate because the symptoms did not correlate with the portions of the cervical spine proposed for fusion. [redacted] further explained that the requested surgery was medical necessary because neurological conditions had not been investigated, and because there had been no documented trial and failure of conservative non-surgical methods. (Exhibit 1, pages 18-21).

Because the Appellant's documentation lacked a demonstration of medical necessity and appropriateness, the MHP said it denied the fusion authorization.

The Michigan Medicaid policy related to surgery is as follows:

> **SECTION 12 – SURGERY - GENERAL**
>
> Medicaid covers medically necessary surgical procedures.
>
> (Emphasis added by ALJ).
>
> *MDCH Medicaid Provider Manual, Practitioner Section, January 1, 2008, page 60*.

An analysis of the MHP's criteria for cervical spine fusion surgery concludes that it is consistent with the Medicaid policy listed above. A review of the documentation sent in by Appellant's health care provider as part of the request for cervical spine fusion surgery authorization showed that Appellant did not have documentation that conservative methods had been tried and failed thus proving lack of medical necessity. Further, the clinical findings were inconsistent with the proposed location of cervical spine fusion, also supported a finding of lack of medical necessity for the C4-C5 fusion.

The Appellant's Representative/mother testified that the Appellant wakes every day with a headache, pain in her neck and has numbness in her limbs. [redacted] explained that problems in the spine area of C4/5 do not manifest in headaches and arm numbness. Appellant's Representative/mother expressed frustration about not knowing what to do for Appellant's headaches and pain if the surgery wasn't a guaranteed cure.

The MHP properly denied the request for cervical spine fusion surgery because from the medical documentation provided, medical necessity and appropriateness were not established.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied Appellant's request for cervical spine fusion surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/26/2010

***** 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.