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. 2010-36171 QHP
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. The Appellant was represented by [redacted] and [redacted], represented [redacted], the Medicaid Health Plan. [redacted] and [redacted], were also present.

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. The Appellant is a [redacted] male Medicaid beneficiary.

2. The Appellant was formerly a fee for service Medicaid beneficiary.

3. The Appellant has a diagnosis of Lumbosacral neuritis NOS. His medical records indicate he has significant stenosis at the L4-5 level with a disc bulge with a far right lateral component creating severe lateral recess stenosis at the L4-5 level with impingement on the L5 nerve. Scanning of the cervical and thoracic spine shows multilevel degenerative disc disease without central stenosis. (Respondent Exhibit A, p. 17).

4. The Appellant has a closed head injury and seizure disorder. (Respondent Exhibit A, p. 13, 17).

5. The Appellant has participated in physical therapy multiple times according to correspondence from [redacted]. (Appellant's Exhibit A, page 2).

6. The Appellant's neurologist states the Appellant is unable to participate in physical therapy at this time due to the pain constraints he is experiencing. (Appellant's Exhibit A, page 1)

7. The Appellant is no longer exempt from enrollment in a Medicaid Health Plan, thus was enrolled into [redacted].

8. The Appellant's physician requested prior authorization for continuation of pain injections on [redacted].

9. The Health Plan requested documentation of participation in physical therapy, along with other clinical documentation.

10. On [redacted], the MHP denied the request for prior authorization for the steroidal epidural injections, citing a lack of clinical documentation of at least 6 months participation in physical therapy, indicating "physical therapy has to be tried for at least six months before injections can be done. There is no record of any current therapy." (Respondent's Exhibit A, page 20)

11. [redacted], the Appellant requested a formal, administrative hearing contesting the denial.

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 coverage(s) and limitations. (Emphasis added by ALJ)* 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:

- 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.

As stated in the Department-MHP contract language above, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) states:

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

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4.13 INJECTABLE DRUGS AND BIOLOGICALS

4.13.A. COVERAGE OF THE INJECTABLE

Medicaid covers injectable drugs and biologicals administered by a physician in the office or clinic setting and the beneficiary's home. The drug must be Federal Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the beneficiary.

An injectable drug is covered if the drug is:

- Specific and effective treatment for the condition for which it is being given.
- Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient).
- Administered by the recommended or accepted administration method for the condition being treated.

- Administered according to the recommended dosing schedule and amount for the condition being treated.

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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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> *Department of Community Health,*
> *Medicaid Provider Manual, Practitioner Section*
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The MHP testified that they applied their own policy when reviewing the Appellant's prior authorization request for pain injections, which requires documentation of a recent trial of physical therapy. As stated in the denial notices, the MHP requires a physical therapy trial for at least six (6) months before injections can be done. (Respondent's Exhibit A) The requirement of a recent six (6) month trial of physical therapy is not consistent with the above cited Medicaid Provider Manual policy. It is also noted that the requested service codes (62311 or 64483) would be covered without prior authorization for a straight Medicaid beneficiary, *i.e*. a Medicaid beneficiary who is not enrolled in an MHP. (MDCH Practitioner Medical Clinic Database January 1, 2010, pages 140, 145, and 185)

Further, the MHP policy itself does not clearly require a recent six (6) month trial of physical therapy. The submitted MHP policy requires that the patient has been unresponsive or poorly responsive to a well-designed course of conservative therapy. (Respondent's Exhibit A) Conservative therapy is not synonymous with recent physical therapy. Physical

therapy may be a component of a well designed course of conservative therapy, but is not an explicit requirement.

Importantly, the material issue is whether the denial is consistent with the coverage that is provided to Medicaid beneficiaries who are not participants in a Medicaid Health Plan. The uncontested material facts establish the Appellant not only would be covered for the treatment sought if not for being enrolled with [redacted], but actually was covered for a number of years as a fee for service Medicaid beneficiary. (Appellant's Exhibit A) Additionally, the procedure codes are for covered services and do not even require prior authorization for fee for service Medicaid beneficiaries. The material facts do not support the determination made by [redacted]. The MHP improperly denied the Appellant's prior authorization request for lack of documentation of a recent trial of physical therapy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent MHP improperly denied the Appellant's prior authorization request for lumbar epidural steroid injections.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/9/2010

***** 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.