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:

Docket Nos. 2010-41463 QHP
2010-46487 QHP

[redacted]

[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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared on her own behalf. [redacted], the Appellant's chore provider, appeared as a witness for the Appellant. [redacted], Director of Member Services, represented the Medicaid Health Plan (MHP), [redacted], Director of Care Management, and [redacted], Medical Director for Utilization, appeared as witnesses for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for lumbar L5-S1 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 the MHP.

2. The Appellant is a [redacted]e, who has been diagnosed with degenerative disc disease, rheumatoid arthritis, and fibromyalgia. (Exhibit 1, page 14; Testimony of [redacted]).

3. On [redacted] the Appellant underwent a lumbar fusion at L5-S1. (Exhibit 1, pages 26-27) However, there were post-surgical changes to the fusion site. (Exhibit 1, page 8)

4. In [redacted], the MHP received the Appellant's request for lumbar spine fusion surgery [L5-S1] from the Appellant's neurosurgeon. (Exhibit 1, page 8).

5. The MHP forwarded the medical documentation to an external, independent medical reviewer, board certified in neurological surgery. (Exhibit 1, pages 17-21).

6. On [redacted], the independent medical reviewer issued a report in which he found that the requested surgery was not appropriate because the Appellant did not meet [redacted] criteria. Specifically, there was insufficient clinical documentation to support any type of surgery and the Appellant's neurosurgeon failed to specify the surgical procedure he intended to perform. (Exhibit 1, pages 17-21)

7. On [redacted], the MHP sent a letter to the Appellant, stating that the request for lumbar spine fusion surgery was denied because she did not meet medical necessity coverage criteria. The MHP letter stated that Appellant had not provided the following: (1) documentation of trial and failure of conservative non-surgical methods, (2) imaging or x-rays to support instability or grade 4 spondylolisthesis, (3) clinical documentation to support the requested procedure, and (4) evidence the Appellant stopped smoking. (Exhibit 1, pages 22-23)

8. On [redacted], the Appellant filed an internal grievance/appeal. (Exhibit 1, page 7) At that time, additional clinical documentation was submitted for the MHP's review. (Exhibit 1, pages 25-30)

9. The MHP again forwarded all medical documentation to an external, independent medical reviewer, board certified in neurological surgery. (Exhibit 1, pages 31-34).

10. On [redacted], the independent medical reviewer issued a report in which he found that the requested surgery was not appropriate because the Appellant again failed to meet [redacted] criteria. Specifically, while the reviewer noted that the Appellant may need exploration of the lumbar spine to check for a failed fusion, the Appellant's neurosurgeon failed to specify the procedure he intended to perform on the Appellant. (Exhibit 1, page 31-34)

11. On [redacted] the MHP sent a second letter the Appellant, denying her internal grievance/appeal for the same reasons as set forth in the [redacted] denial letter. (Exhibit 1, pages 35-37)

12. 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. The Contractor 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 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(3) The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA)(1) and (2),
Utilization Management, Contract,
October 1, 2009.

The MHP's Director of Care Management testified that the medical documentation submitted for the Appellant raised a question about the medical necessity and appropriateness of the spinal fusion. She explained that the request for lumbar spine fusion surgery was forwarded to two external board-certified neurological surgeons, who both issued reports finding that the spinal fusion was not appropriate because the Appellant's neurosurgeon had failed to state the specific surgery he intended to perform on the Appellant. She further explained that the Appellant failed to meet the MHP's

criteria for the surgery because there had been no documented trial and failure of conservative non-surgical methods and the Appellant had failed to stop smoking. (Testimony of [redacted]). The MHP's Medical Director added that the Appellant's x-rays also did not support an instability in her spine. The MHP witnesses testified that it denied the fusion authorization for all of these reasons.

The Michigan Medicaid policy related to surgery is as follows:

> **SECTION 12 – SURGERY - GENERAL**
>
> Medicaid covers medically necessary surgical procedures.
>
> (Emphasis added by ALJ).
>
> *Michigan Department of Community Health,*
> *Medicaid Provider Manual,*
> *Practitioner Section,*
> *April 1, 2010, page 60*.

The Appellant testified that she is in severe pain and uses a walker. She stated that she has been treating with her neurosurgeon for three years and that he placed a plate in her neck in [redacted], and performed a spinal fusion in [redacted]. Her neurosurgeon advised her that she did not heal properly from the [redacted] surgery, so he wants to go back in and place screws in her back.

The Appellant also testified that she has tried several pain medications, including motrin, vicodin, loracet, and loratab, without relief. She has also tried the muscle relaxer flexerol. However, she admitted that she has not attempted physical therapy post-surgery, but she stated that she would be willing to give it a try. She also stated that she would try injections. The Appellant further testified that she has quit smoking.

An analysis of the MHP's criteria for lumbar spine fusion surgery concludes that it is consistent with the Medicaid policy listed above. A review of the documentation sent in by Appellant's neurosurgeon with the request for lumbar spine fusion surgery authorization failed to show that physical therapy had been tried and failed. Additionally, the Appellant's neurosurgeon's failure to identify a specific procedure to be performed on the Appellant also supported a denial in this matter.

The MHP properly denied the request for lumbar spine fusion surgery because, from the medical documentation provided, the Appellant does not meet the criteria for the procedure.

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 lumbar spine fusion surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/4/2010

***** 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.