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. 2010-42524 QHP
[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 hearing request.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted] appeared on his own behalf. [redacted], RN/Clinical Appeals, represented [redacted] the Medicaid Health Plan (MHP). [redacted] RN/Team Lead for Medical Management, testified as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for facet joint injections?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary enrolled in the MHP, [redacted].

2. The MHP contracts with the Department of Community Health to provide medically necessary, Medicaid-covered services.

3. The Appellant is a [redacted] male with a medical history of low back pain. (Exhibit 1, page 2)

4. On [redacted], the MHP received a prior-authorization request from the Appellant's physician for facet joint injections, and the MHP requested additional clinical documentation from the Appellant's physician. (Exhibit 1, page 2; Testimony of [redacted]

5. On [redacted], the MHP received additional clinical documentation from the Appellant's physician. (Exhibit 1, pages 3-6)

6. On [redacted] the MHP sent Appellant and his physician written notice that the prior-authorization request was denied because the Appellant had not completed six months of physical therapy. (Exhibit 1, pages 20-31)

7. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's Request for Hearing, contesting the MHP's 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. 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.

(2) Prior Approval Policy and Procedure

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.

In this case, the Appellant is contesting the MHP's denial of his request for facet joint injections. According to the Appellant, he is in constant pain; in fact, some days he cannot even walk. He explained that he was assaulted in [redacted], which resulted in him being in a wheelchair for 18 months. He participated in physical therapy in [redacted] and [redacted] but not since. He explained that he is unable to take time off work to attend physical therapy, and the closest physical therapist is located an hour away from him. Instead, he testified that he has treated with several different doctors regarding his back pain, and has tried several medications, including Vicodin, Tylenol-3, Ibuprofen, Demerol, and Flexoril.

The MHP submitted a copy of its policy for coverage of facet joint injections. One of the criteria required for the injections is that the beneficiary must have been unresponsive to a well-designed course of conservative therapy over a period of six months or longer before authorization of this therapy. (Exhibit 1, page 18)

As stated above, the MHP must cover services consistent with the scope of services covered by the Michigan Medicaid fee-for-service program. However, the "MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. *Department of Community Health, Medicaid Provider Manual, Medicaid Health Plan, July 1, 2010, pages 1.*

Here, the MHP denied the request because it did not receive documentation that the Appellant had completed a well-designed course of conservative therapy for the required period of time. The Appellant admits that he has not participated in physical therapy since [redacted] And the MHP witnesses explained that while the Appellant's trial and failure of various medications may be considered conservative therapy that would satisfy its criteria, the Appellant's physician failed to submit any documentation to support that testimony. The MHP must rely on the documentation that was provided with the request to make its determination. Accordingly, its denial in this case was proper. However, the Appellant may re-apply at any time with the proper documentation.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for facet joint injections.

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: 10/7/2010

*** 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.