STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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]

Docket No. 2012-53891 QHP
Case No. [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]. [redacted] appeared on [redacted] own behalf. [redacted] on [redacted] ("[redacted]"). [redacted] present.

ISSUE

Did the MHP properly deny Appellant's request for Magnetic Resonance Imaging ("MRI") of the lower back?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary who is currently enrolled in the Respondent MHP.

2. On or about [redacted], the [redacted] received a request for MRI L-spine without contrast from the Appellant's physician. The request indicates that the Appellant has been diagnosed with low back pain. (Exhibit 1, pages 11-13)

3. On [redacted] the [redacted] sent the Appellant a denial notice stating that the request for MRI lumbar spine was denied for medical necessity because the submitted documentation did not meet the InterQual Imaging,

MRI, lumbar spine criteria as the InterQual guidelines require examination findings including documentation of weakness, or abnormal reflexes, or abnormal plain x-rays and a trial of conservative therapy like medications and physical therapy or a home exercise program. (Exhibit 1, pages 14-17)

4. On [redacted] the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System.

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 s ervices to those whic h are m edically necessary and appropriate, and which conform t o professionally accepted standards of care. Contractors must operate c onsistent wit h all applic able M edicaid provider manuals and public ations fo r c overage(s) and limit ations. (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.
>
> *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 [redacted] contract language above, a [redacted] "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

10.1 RADIOLOGY SERVICES

Medically necessary radiological services are covered when ordered by a physician to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other imaging procedures. Medical need for all services must be documented in the medical record and are subject to post-payment review.

Michigan Department of Community Health,
Medicaid Provider Manual, Practitioner
Version Date: April 1, 2012, Page 52.

The [redacted] contract provisions allow prior approval procedures for utilization management purposes. The Inquiry Dispute Appeals Resolution Coordinator explained that for a lower back MRI, the MHP reviews prior approval requests under the InterQual Imaging, MRI Lumbar Spine Criteria. (Exhibit 1, pages 2-10) The InterQual guidelines, in part, state:

> While MRI is becoming a routine part of the preoperative evaluation for chronic low back pain, its use in this context is considered controversial because the efficacy of the surgery itself remains unproven. Requests for MRI for chronic back pain without underlying pathology requires secondary medical review.
>
> (Exhibit 1, page 5)

The [redacted] clinical note submitted with the prior authorization request indicates the Appellant has back pain (lumbar) and a history of disc disease. (Exhibit 1, page 12) The InterQual MRI lumbar spine guideline for the indication of degenerative disk disease requires:

400 Degenerative disc disease by x-ray **[All]**

- 410 Back pain interferes with ADLs
- 420 No neurologic Sx/findings
- 430 X-ray findings **[All]**
  - 431 Disc space narrowing
  - 432 Osteophyte formation
  - 433 End-plate sclerosis
- 440 Continued symptoms **after** Rx **[All]**
  - 441 NSAID **[One]**
    - -1 RX≥ 3 wks
    - -2 Contraindicated/not tolerated
  - 442 Activity modification ≥ 6 wks
- 450 Preoperative evaluation

The [redacted] denied the prior authorization request because the submitted documentation showed lower back pain with tenderness, but did not include: examination findings documenting weakness or abnormal reflexes, abnormal plain x-rays, and a trial of conservative therapy like medications and physical therapy or a home exercise program. (Exhibit 1, pages 1 and 14)

The Appellant disagrees with the denial and testified that x-rays have been taken recently. (Appellant Testimony)

Under its contract with the Department, an [redacted] may devise criterion for coverage of medically necessary services, as long as those criteria do not effectively avoid providing medically necessary services. The [redacted] s MRI lumbar spine prior approval process is consistent with Medicaid policy and allowable under the [redacted] contract provisions. The [redacted] demonstrated that based on the submitted documentation, the Appellant did not meet criteria for approval of an MRI lumbar spine. While low back pain and a history of disc disease was documented, the information submitted did not include x-ray, findings or documentation to establish that other guideline criteria, such as a trial of conservative therapy, were met. The [redacted]'s determination is upheld.

The Appellant may wish to have her doctor submit a new prior authorization request to the MHP with additional documentation supporting that the criteria for MRI lumbar spine have been met, such as the recent x-ray findings, additional examination findings and any trials of conservative therapy.

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 an MRI of the lower back based on the submitted documentation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Signed: _____

Date Mailed: _____

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.