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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-11556 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], the Appellant, appeared on her own behalf. [redacted]igler, Inquiry Dispute Appeals Resolution Coordinator, represented Molina Healthcare of Michigan, the Medicaid Health Plan ("MHP"). [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for continued chiropractic services?

FINDINGS OF FACT

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

1. The Appellant is a [redacted]-year-old female Medicaid beneficiary who is currently enrolled in the Respondent MHP. (Exhibit A, p 8).

2. On or about [redacted], the MHP received a Prior Authorization request for continued chiropractic services from the Appellant's chiropractor. (Exhibit A, pp 8-11).

3. On [redacted], the MHP sent the Appellant and her chiropractor a denial notice stating that the Prior Authorization request was denied based on the InterQual criteria for the requested continued chiropractic services. (Exhibit A, pp 12-13).

4. On [redacted], the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1)

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 [redacted], 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.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans,* [redacted].

> 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, [redacted].

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 section of the Michigan Medicaid Provider Manual (MPM) states:

SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays.

Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation.

If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray

requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary.

Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date; including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis; including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and
- Include any additional details, comments, etc. that may be of assistance in the evaluation.

SECTION 4 – NONCOVERED SERVICES

Chiropractic services excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:

- Consultations

- Fracture care
- Home visits
- Injections
- Laboratory tests
- Maintenance therapy
- Medical supplies
- Evaluation and Management services
- Plaster casts
- Inpatient hospital visits

Michigan Department of Community Health,
Medicaid Provider Manual, Chiropractor
Version Date: [redacted]*, pp 1-5*

The DCH-MHP contract provisions allow Prior Approval procedures for utilization management purposes. The MHP reviews prior approval requests under the InterQual Imaging criteria. For continued chiropractic services, a provider must show documented improvement in function and reduction in limitations along with reduction in intensity and reduction in frequency of symptoms / findings. (Exhibit A, pp 2-3).

The Medical Director testified that patients are allowed three initial chiropractic visits before additional information is required. The Medical Director indicated that the additional clinical documentation submitted by Appellant's chiropractor did not establish documented improvement in function and reduction in limitations along with reduction in intensity and reduction in frequency of symptoms / findings. The additional information submitted by Appellant's chiropractor simply included another Prior Authorization request for more services and Appellant's initial evaluation. (Exhibit A, pp 8-11.)

The Appellant testified that she did not understand why she was denied additional chiropractic services because she did show improvement following the initial visits. The Appellant indicated that her chiropractor informed her that they would submit additional information to the MHP so that additional visits would be covered. The Appellant also indicated that the chiropractor has billed her for the additional visits she did have that were not approved through prior authorization and that she cannot afford to pay this bill.

The Medical Director testified that the provider can not charge the Appellant for services they failed to obtain prior authorization for and that he would have someone from the MHP contact the provider to remind them of this fact.

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criteria do not effectively avoid providing medically necessary services. The MHP's chiropractic prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. A close look at the additional documentation submitted by Appellant's chiropractor supports the MHP's position that the provider failed to show documented improvement

in function and reduction in limitations along with reduction in intensity and reduction in frequency of symptoms / findings. The MHP's determination is upheld based on the documentation submitted with the [redacted] prior authorization request.

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 continued chiropractic services based on the submitted documentation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

/s/

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: January 29, 2013

***** 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.