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. 2013-19892 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 on [redacted]. [redacted], the Appellant, appeared on his own behalf. [redacted], [redacted], represented [redacted], the Medicaid Health Plan ("MHP"). [redacted], appeared as a witness for the MHP.

ISSUE

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

FINDINGS OF FACT

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

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

2. On [redacted] the MHP received a prior authorization request for MRI lumbar spine for the Appellant listing a diagnosis of back pain unspecified. Documentation from a [redacted] office visit was included. (Exhibit 1, pages 6-8)

3. On [redacted], the MHP sent the Appellant a denial notice stating that the prior authorization request was denied based on the InterQual guidelines, which requires examination findings including clinical notes showing weakness, reflex changes, significantly abnormal plain x-rays or nerve tests and a recently failed trail of prescription medications and physical therapy or a home exercise program. (Exhibit 1, pages 9-12)

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 MHPs.

> 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:
>
> - 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 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), Utilization Management,
MDCH contract (Contract) with the Medicaid Health Plans*,*
October 1, 2009.

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:

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: October 1, 2012, Page 53.

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviews prior approval requests under the InterQual Imaging guidelines. (Exhibit 1, pages 2-7) In part, the guidelines list several indication for MRI of the lumbar spine:

> Magnetic Resonance Imaging (MRI), Lumbar Spine
>
> INDICATION(S) (Chose one and see below)
>
> 100 Suspected nerve root compression by lumbar disc herniation/foraminal stenosis
> 200 Suspected lumbar spinal stenosis
> 300 Suspected cauda equina syndrome
> 400 Degenerative disc disease by x-ray
> 500 Suspected lumbar spine injury with neurological deficit at/distal to injury
> 600 Suspected nerve root compression by tumor/metastasis (gadolinium contrast recommended)
> 700 Suspected bone metastasis (gadolinium contrast recommended)
> 800 Follow-up bone metastasis after Rx
> 900 Preoperative evaluation of osteomyelitis (gadolinium contrast recommended)
> 1000 Suspected osteomyelitis/disc space infection gadolinium contrast recommended)
> 1200 Suspected meningocele post lumbar spine surgery gadolinium contrast recommended)
> Indication not Listed (Provide clinical justification below)
>
> (Exhibit 1, page 2)

The InterQual guidelines continue, listing criteria for each indication. The criteria for may of these indications includes examination findings showing weakness, numbness, abnormal x-rays, and a failed trail of prescription medications, physical therapy or activity modification. (Exhibit 1, pages 2-7)

In the present case, the MHP denied a request for a MRI lumbar spine. The documentation submitted with the prior authorization request only included one office visit record. (Exhibit 1, pages 7-8) The Medical Director explained that the submitted documentation was very limited and did not meet the InterQual criteria. The office visit report did not even document an exam. (Medical Director Testimony)

The Appellant testified the injury occurred at physical therapy. The Appellant asserted that this shows a failure of physical therapy. The Appellant also described changes to

medications, and stated it has been 6 months since the injury and he can barely walk. The Appellant noted that no documentation from physical therapy was included. (Appellant Testimony)

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 MRI prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. The limited information submitted with the [redacted] prior authorization request was not sufficient to meet the InterQual criteria. For instance, there was no documentation of the injury, duration of back pain, physical therapy records, any x-rays or other testing completed so far. The note indicates the Appellant has low back pain, multiple joint pains to neck, bilateral wrists and back. The note indicates the Appellant is seeing pain management, but not what specific treatment(s) have been tried, duration of treatment and the results of these treatments. (Exhibit 1, pages 7-8) The submitted documentation was insufficient to establish the medical necessity for the MHP to cover the requested MRI lumbar spine. The MHP's determination is upheld based on the documentation submitted with the [redacted] prior authorization request.

The Appellant may wish to have his doctor submit a new prior authorization request with additional documentation supporting the medical necessity of the requested MRI.

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 MRI lumbar spine based on the submitted documentation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/S/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/14/2013

***** 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.