

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:

██████████,

Appellant

Docket No. 2013-50031 QHP
Case ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a telephone hearing was held on ██████████. ██████████, the Appellant, appeared on her own behalf. ██████████, boyfriend, was present for part of the hearing proceedings as a potential witness for the Appellant.

██████████ was represented by ██████████, Director of Medicaid. ██████████ is a Department of Community Health contracted Medicaid Health Plan ("MHP").

The hearing record was left open for the MHP to submit documentary evidence, which was received on ██████████.

ISSUE

Did the MHP properly deny the Appellant's request for spinal 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. The Appellant is a ██████ year old Medicaid beneficiary who is currently enrolled in the Respondent MHP, Priority Health. (Exhibit 1, page 4)
2. On or about ██████████, the MHP received a request for prior authorization for spinal fusion surgery for the Appellant listing a diagnosis of lumbar degenerative disc disease. (Exhibit 1, pages 4-9)
3. On ██████████, the MHP issued a letter to the Appellant indicating the prior authorization request was denied based on the information provided. The letter indicated the information provided did not meet the

MHP's medical necessity criteria for the requested procedure. (Exhibit 1, pages 20-22)

4. The Appellant requested a Peer Review Determination. (Hearing Request; Appellant Testimony)
5. The MHP scheduled a Peer Review for ██████████. (Hearing Request)
6. On or about ██████████, the Appellant's doctor told the Appellant the Peer Review determination was also a denial. (Hearing Request; Appellant Testimony)
7. In ██████████ the Appellant called the MHP because she had not received written notice of the Peer Review determination. During this call, the Appellant was told that she could file an appeal. (Hearing Request; Appellant Testimony)
8. On ██████████, the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Hearing Request)

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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)

- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

- (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.

....

Contract, *Supra*, p. 49

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 sections of the Michigan Medicaid Provider Manual (MPM) state:

SECTION 12 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

*Michigan Department of Community Health
Medicaid Provider Manual;*

Practitioner Version Date: January 1, 2013, Page 58

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior approval request under the MHP’s Medical Policy for Lumbar Fusion. In part, the Medical Policy states:

Lumbar spinal fusion is covered per the indications listed below:

Indications that are covered - prior authorization required.

Lumbar fusions are considered medically necessary for spinal instability associated with any of the following conditions:

1. Spinal fracture with either spinal instability of neural compression.
2. Spondylolisthesis with or without spondylosis, OR spinal stenosis
 - a. Associated lumbar spondylolisthesis or stenosis demonstrated on x-ray, CT/MRI
 - b. Back Pain, neurogenic claudication or radicular pain from lateral recess or foraminal stenosis
 - c. Functional impairment (interferes with ADLS)
 - d. X-ray abnormality (not needed with CT or MRI)

- i. Instability by x-rays: sagittal plane translation > 3 mm or 15% of vertebral body width, or
 - ii. Relative sagittal plane angulation of 22 degrees
 - e. Documented unremitting pain for at least 6 months that is refractory to intensive conservative therapy for at least 12 weeks
 - f. Participation in the SCOE physiatry program
3. Spinal repair as needed in operations for dislocation, abscess/infection and/or tumor
4. Severe degenerative scoliosis with one or more of the following:
 - a. Curvature > 50 degrees with loss of function;
 - b. Persistent significant radicular pain or weakness unresponsive to conservative care;
 - c. Persistent neurologic claudication unresponsive to conservative care.
5. Spinal tuberculosis.
6. Intra-operative spinal instability

Indications that are not covered

Lumbar fusions are not considered medically necessary or covered for the management of the following conditions:

1. Spinal degeneration without instability
2. With initial primary laminectomy/discectomy for nerve root decompression without documented instability
3. Multiple-level degenerative disc disease (more than 3 levels/vertebrae)
4. Minimally invasive fusions
5. Chronic discogenic back pain
6. Sacroiliac (SI) joint fusion for back pain
7. All other conditions not listed under "Indications that are covered"

(Exhibit 1, pages 10-11)

These criteria are consistent with the Medicaid standard of coverage to provide only medically necessary surgeries, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

The MHP has made multiple requests for the a dismissal of this case based on the ██████████
██████████ Request for Hearing being filed more than 90 days after the ██████████
denial notice issued by the MHP. It appears that the ██████████ denial letter

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issued by the MHP only provided the [REDACTED], Grievance, and Expedited review process information and did not include notice of the Appellant's right to request a Michigan Department of Community Health Medicaid fair hearing through the Michigan Administrative Hearing System within 90 days of the notice. (Exhibit 1, pages 20-22) Further, as noted in the [REDACTED] ORDER DENYING REQUEST TO DISMISS HEARING, the Appellant is contesting the [REDACTED] denial from the Peer Review determination. The Appellant's credible testimony indicates she requested an internal appeal with the MHP and a Peer Review was scheduled for [REDACTED]. On or about [REDACTED], the Appellant's doctor told the Appellant the Peer Review determination was also a denial. In [REDACTED] the Appellant called the MHP because she had not received written notice of the Peer Review determination. During this call, the Appellant was told that she could file an appeal. The Appellant never received written notice of the Peer Review determination. (Hearing Request; Appellant Testimony) During the [REDACTED] telephone hearing proceedings, the MHP's Director of Medicaid confirmed that there was a Peer Review, which upheld the denial. The MHP's Director of Medicaid did not confirm the date of the Peer Review determination but stated she would rely on the Appellant's testimony as accurate. (Director of Medicaid Testimony) Accordingly, the MHP's request for a dismissal is denied.

The MHP asserts that the Appellant did not meet the medical necessity criteria found in the above cited Medical Policy for Lumbar Fusion. (Exhibit 1) The MHP's Medical Director also reviewed this request and concurred with the denial. (Director of Medicaid Testimony)

The Appellant disagrees with the denial and testified she was covered by a private HMO before enrollment in the MHP. The Appellant went through extensive physical therapy three times per week, aquatic and land therapy. Physical therapy was not helping. The Appellant was in pain management from [REDACTED] through [REDACTED]. The Appellant has been through trigger points, injections, and adjustments. The Appellant has failed medications. The Appellant has a \$ [REDACTED] back brace that does her no good. The Appellant described pinching she experiences from the left to right side of her lower back. Sometimes the Appellant hurts so bad she can barely walk. The Appellant cannot lift her child. The Appellant tried everything she could before considering surgery, and did not want surgery right away. The Appellant does not know what more she can change and explained this has changed her lifestyle. The Appellant can hardly do anything at all. For example on a good day, if the Appellant does a little bit of housework, she had to rest for an hour and then try another 20 minutes of housework and rest for another hour. The Appellant stated her doctor told her this is a much needed surgery and she should fight for it. (Appellant Testimony)

The MHP provided sufficient evidence that its denial was consistent with Medicaid policy and allowable under the DCH-MHP contract provisions based on the information submitted with the [REDACTED] prior authorization request. The [REDACTED] MRI report documented degenerative disc disease and disc bulging at the L4-L5 level. (Exhibit 1, pages 5-6) However, the medical records did not establish instability with the spinal degeneration. The medical records did not establish that the Appellant

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met any of the other indications in the above cited Medical Policy for Lumbar Fusion for the requested surgery to be considered medically necessary. (Exhibit 1, pages 4-9) Accordingly, the MHP's determination must be upheld.

As discussed during the telephone hearing proceedings, at any time the Appellant can have a new prior authorization request submitted to the MHP with additional documentation supporting the medical necessity of the requested surgery.

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 spinal fusion surgery based upon the available information.

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

Date Signed: 8/12/2013

Date Mailed: 8/12/2013

CC: [REDACTED]

***** NOTICE *****

The Michigan Administrative Hearing System 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.