

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:

Docket No. 2013-60168 QHP

██████████,

██████████

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 ██████████ ██████████ the Appellant, appeared on her own behalf. ██████████ Appeals Coordinator, represented ██████████ the Medicaid Health Plan ("MHP"). ██████████, Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for Computed Tomography ("CT") scan of the abdomen and pelvis?

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 or about ██████████, the MHP received a prior authorization request for CT scan of abdomen and pelvis for the Appellant listing diagnoses of abdominal pain and pancreatitis. There was no supporting clinical documentation, only the single page prior authorization form was submitted. (Exhibit 1, page 14; Medical Director Testimony)
3. On ██████████, the MHP sent the Appellant a denial notice stating that the prior authorization request was denied based on the InterQual criteria for the requested CT scan, which requires documentation showing recent examination findings, blood and urine tests, preliminary imaging such as ultrasound or endoscopy tests and any treatment received to date. The medical records were not received; there is no evidence of these requirements being met. (Exhibit 1, pages 15-16)

4. On [REDACTED], the Appellant's unsigned Request for Hearing was received by the Michigan Administrative Hearing System. On [REDACTED], the hearing request was re-submitted with the Appellant's signature.

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:
 - (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.

....

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:

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: July 1, 2013, Page 55.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviews prior approval requests under the InterQual Imaging criteria. (Exhibit 1, pages 2-13) Regarding a CT for acute abdominal pain, the criteria states:

- 500 Acute abdominal pain, unknown etiology **[All]**
- 510 Abdominal tenderness
- 520 CBC normal
- 530 Serum/urine culture normal **[One]**
 - 531 Negative
 - 532 Not indicated
- 540 U/A or urine culture normal
- 550 Cervical cultures **[One]**
 - 551 Gonorrhea test negative and no chlamydia by DNA/antibody testing
 - 552 Not indicated

(Exhibit 1, pages 3-4)

On or about ██████████, the MHP received a prior authorization request for CT scan of abdomen and pelvis for the Appellant listing diagnoses of abdominal pain and pancreatitis. There was no supporting clinical documentation, only the single page prior authorization form was submitted. The InterQual criteria sets out the criteria for CT scans by indication, for example the above excerpt sets out the criteria for a CT of the abdomen and pelvis for the indication of abdominal pain. Without supporting clinical

documentation, it cannot be established that the Appellant met the criteria for the requested CT of her abdomen and pelvis. (Exhibit 1, page 14; Medical Director Testimony)

The Appellant disagrees with the denial, but did not know that no supporting documentation was submitted for the CT request. The Appellant thought the doctors had given the needed information to the MHP. The Appellant has been in and out of the hospital frequently. The Appellant goes in every month and is only out for a few weeks before she is back in the hospital. (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 CT scan prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. The [REDACTED] prior authorization request was submitted without any supporting clinical documentation. The submitted information was not sufficient to determine that the Appellant met the criteria for the requested CT of her abdomen and pelvis. Medical necessity could not be established based on the information available to the MHP at the time this prior authorization request was reviewed. The MHP's determination must be upheld based on the available information.

If she has not already done so, the Appellant may wish to have her doctor submit a new prior authorization request with clinical documentation to the MHP.

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 CT scan of abdomen and pelvis based on 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: [REDACTED]

Date Mailed: [REDACTED]

[REDACTED]
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CL/db

cc:

[REDACTED]

***** 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.