

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. 2013-62358 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 on ██████████ Appellant, appeared and testified. ██████████ Appeals Coordinator, represented ██████████, the Medicaid Health Plan (MHP). ██████████, Medical Director, testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for an MRI and back brace?

FINDINGS OF FACT

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

1. Appellant is a ██████ year old female Medicaid beneficiary who is currently enrolled in the Respondent MHP.
2. On ██████████ the MHP received a completed Prior Authorization Request Form from Appellant's physician, requesting an MRI of Appellant's lumbar spine; and the MHP received a prior authorization request for a back brace. (Department Exhibit A)
3. Appellant was given a diagnosis of low back pain. (Department Exhibit A).
4. Appellant provided numerous office/physical examination reports to the MHP, which show that she was prescribed medications for her

back pain; low back stretching and strengthening exercises were recommended; and it was recommended that she go to the pain clinic for chronic back pain. (Department Exhibit A, pp. 8,9,11,14,16,17,19,21,24,27 & 28)

5. On ██████████ the MHP sent the Appellant a denial notice, stating that the MRI of the lumbar spine was denied on the basis that: “InterQual Imaging, Magnetic Resonance Imaging (MRI), Lumbar Spine criteria requires evidence of one-sided weakness or loss of reflexes on examination, or failure of at least three weeks of treatment with anti-inflammatory medications and a recently completed home exercise program (HEP) or course of physical therapy. The medical records we received show you have back pain and no report of recent physical therapy. There is no evidence of these requirements being met. Please discuss your healthcare concerns with your provider.” (Department Exhibit A, p. 30)
6. The MHP denied Appellant’s request for a back brace.
7. On ██████████ the Appellant’s Request for Hearing, protesting the denial of the MRI and back brace, 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 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 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 1-Z.

Article II-G, Scope of Comprehensive Benefit Package.
MDCH contract (Contract) with the Medicaid Health Plans,
September 30, 2004, Page 30.

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 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 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.*

The MHP testified that the prior authorization request for the back brace should have been approved for Appellant as she meets the eligibility criteria. Therefore, the only issue to be resolved is whether the denial of the MRI request was proper.

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

SECTION 10 – RADIOLOGY, RADIATION THERAPY AND NUCLEAR MEDICINE
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, CTscan 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.

*Department of Community Health,
Medicaid Provider Manual, Practitioner Section
Version Date: April 1, 2013*

Appellant was denied coverage for an MRI of the lumber spine on the basis that medical documentation was not provided to establish that Appellant met the eligibility criteria. The MHP denied the request on the basis that the InterQual guidelines require evidence of one-sided weakness or loss of reflexes on examination, or failure of at least three weeks of treatment with anti-inflammatory medications and a home exercise program or physical therapy. The medical documentation provided by Appellant establishes that she was diagnosed with back pain; however, there was no mention of any activity modification or physical therapy. Appellant was prescribed pain medication by her treating physician, and low back stretching and strengthening exercises were recommended.

The MHP must cover services consistent with the scope of services covered by the Michigan Medicaid fee-for-service program. As stated above, the health plan may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. In this case, the MHP's denial is in accordance with the applicable Medicaid policy and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

- (1) The MHP properly denied Appellant's request for an MRI of her lumbar spine.
- (2) The MHP's denial of Appellant's request for a back brace was improper.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision regarding the denial of the MRI is **AFFIRMED**. However, it is **ORDERED** that the MHP shall comply with the applicable Medicaid policy and process the approval for Appellant's back brace.

/s/

Marya A. Nelson-Davis
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

MAND/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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.