

**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. 14-005287 MHP  
Case No. ██████████

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 ██████████. Appellant appeared and testified on his own behalf.

██████████, Inquiry Dispute Appeals Resolution Coordinator, represented ██████████, the Medicaid Health Plan ("MHP"). Dr. ██████████, Medical Director, appeared as a witness for the MHP.

**ISSUE**

Did the Department properly deny the Appellant's prior-authorization request for an MRI of his cervical spine and shoulders?

**FINDINGS OF FACT**

The Administrative Law Judge (ALJ), based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Appellant is a Medicaid beneficiary enrolled with Molina Health Care of Michigan. (Exhibit A, Testimony)
2. On ██████████, Appellant's physician sought prior approval for an MRI of Appellant's cervical spine and shoulders. (Exhibit A, pp 19-22)
3. ██████████ reviewed the request and issued a denial on ██████████, citing internal and Medicaid policy. The denial notice included Appellant's right to a hearing. (Exhibit A, p 23; Testimony)
4. On ██████████, the Michigan Administrative Hearing System received Appellant's 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 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. 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:

- (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.

*Section 1.022(AA)(1) and (2),  
Utilization Management, Contract,  
October 1, 2009.*

As it says in the above Department - MHP contract language, a MHP such as ██████████ ██████████ may limit services to those that are medically necessary and that are consistent with applicable Medicaid Provider Manuals. It may require prior authorization for certain procedures. The process must be consistent with the Medicaid Provider Manual.

The QHP's Medical Director testified that Appellant's request for MRI's of his cervical spine and shoulders were denied based on Inter Qual Imaging Criteria. (Exhibit A, pp 4-18). The QHP's Medical Director testified that Inter Qual Criteria requires evidence of unequal reflexes or weakness on one side, the ruling out of other diagnoses, such as carpal tunnel syndrome and the failure of at least four weeks of anti-inflammatory medications and the use of a home exercise program or physical therapy before the MRI's would be covered. Here, the QHP's Medical Director pointed out that there was no such documentation contained with Appellant's request.

Appellant testified that last Wednesday he visited the pain clinic again and was given another prescription for Norco. Appellant indicated that the medication has helped somewhat, but not entirely. Appellant testified that the new prescription is a higher dose than the first prescription.

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**Decision and Order**

Based on the evidence presented, the MHP properly denied Appellant's request for an MRI of his cervical spine and shoulders based on InterQual Imaging Criteria. As indicated above, InterQual Imaging Criteria requires evidence of unequal reflexes or weakness on one side, the ruling out of other diagnoses, such as carpal tunnel syndrome, and the failure of at least four weeks of anti-inflammatory medications and the use of a home exercise program or physical therapy before the MRI's would be covered. Here, there was no such documentation contained with Appellant's request. As such, the denial was proper.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the denial of the Appellant's request for prior-authorization for MRI's of his cervical spine and shoulders was proper.

**IT IS THEREFORE ORDERED** that:

The QHP's decision is **AFFIRMED**.



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

cc:

[Redacted]

RJM/

[Redacted]

Date Signed:

[Redacted]

Date Mailed:

[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.