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],

Appellant
______________________/

CASE INFORMATION

Docket No.: 14-016576 MHP
Case No.: [REDACTED]
Appellant: [REDACTED]
Respondent: [REDACTED]

HEARING INFORMATION

Hearing Date: [REDACTED]
Start Time: [REDACTED]

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [REDACTED]. Appellant appeared and testified on his own behalf. [REDACTED], Inquiry Dispute Resolution Coordinator for [REDACTED] (MHP) appeared and testified on behalf of the Michigan Department of Community Health (DCH). At the hearing, Appellant's telephone was abruptly disconnected. This Administrative Law Judge attempted to contact him several times, to no avail. The hearing was continued until [REDACTED] at [REDACTED]. The Administrative Law Judge contacted Appellant via telephone on [REDACTED] Appellant stated on the record that he did not wish to proceed with/complete the hearing.

Respondent's Exhibit A pages 1-65 were admitted as evidence without objection.

ISSUE

Did the MHP properly deny the Appellant's request for continued Facet Joint Diagnostic Injections for Chronic pain?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. (MHP) is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.

2. Appellant is a Medicaid benefit recipient who was an enrolled member of at the time of the request for services and continues to be enrolled.

3. The MHP member handbook and certificate of coverage were sent at the time of enrollment.

4. The Member Handbook outlines covers limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.

5. On , Appellant's physician submitted a prior authorization request for Facet Joint Diagnostic injections for chronic Spinal pain (L S 1 (64493 INJ PARAVERT F JNT), L S 2 (64494 INJ PARAVERT F JNT and L S 3 (64495).

6. The diagnosis provided on the Authorization sheet indicates lumbago, spinal stenosis and degeneration of lumbar or lumbosacral intervertebral disc. (Respondent's Exhibit A9)

7. Upon review of the information provided, the request for coverage was denied stating that Appellant has a medical condition of back pain. The Medical Coverage Guidance for Facet Joint diagnostic Injections for Chronic Spinal Pain criteria requires documentation indicating (showing) 80% symptom or pain relief (using visual analog scale or verbal descriptor scale) There is no evidence of symptom or pain relief. (Respondent's Exhibit A59)

8. On Notice of Denial was sent to Appellant, and his medical provider. (Respondent's Exhibit A59)

9. On received a request for a hearing stating, "These injections help me to walk without so much pain. (Respondent's Exhibit A9)

10. Respondent provided Appellant with a copy of the Hearing Summary and attached Exhibits.

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 MHPs.

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/EPSDT 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 request was denied based on the Molina Healthcare Medical coverage Guidance for Facet Joint diagnostic Injections for Chronic Spinal Pain criteria requires documentation indicating (showing) 80% symptom or pain relief (using visual analog scale or verbal descriptor scale). MHP guidelines indicate that therapeutic facet joint injections for back pain are controversial. The American Pain Society does not recommend facet joint injections as a treatment for chronic pain. (Respondent's Exhibit A32)

Appellant has failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied the request for Facet Joint diagnostic Injections for Chronic Spinal Pain under the circumstances. The Molina Healthcare Service Guidance Handbook and Certificate of Coverage, guidance #MCG-030 (Respondent's Exhibit A28) does not allow continued coverage when there has not been 80% symptom or pain relief. In the instant case, the conditions required for coverage were not met based upon the medical information submitted with the Prior Authorization request.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for Facet Joint diagnostic Injections for Chronic Spinal Pain was proper.

IT IS THEREFORE ORDERED that:

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

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed:

Date Mailed:

LYL/db

cc:

*** **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.