

**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. 2014-14447 QHP

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 ██████████. The Appellant appeared and testified.

██████████, the Medicaid Health Plan (MHP) was represented by attorney ██████████. Witnesses on behalf of the MHP included: Dr. ██████████, Medical Director for Utilization Review, and Dr. ██████████, Medical Director for Behavioral Health.

ISSUE

Did the Plan properly deny the Appellant's request for chiropractic visits in excess of 18 per calendar year allowed under the plan coverage limitations?

FINDINGS OF FACT

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

1. Appellant is a ██████ year old Medicaid beneficiary who is a recipient of the SSI program. (uncontested)
2. On or about ██████████ Appellant's chiropractor requested prior authorization for 12 additional chiropractic visits in excess of the 18 visits allowed under Medicaid and plan coverage limitations. (uncontested)
3. The Medical Director determined the request did not meet the "medically necessary" definition for a covered benefit under Medicaid policy.
4. The MHP denial review records indicate in part that the medical necessity criteria

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was not met as there were no imaging reports sent to the MHP for review, and nothing in the notes to show that Appellant has tried and failed with the use of medication therapy or that additional visits will improve Appellant's pain.

5. On ██████████ the MHP issued a Notification of Denied Service informing Appellant that his request for prior authorization for additional chiropractic visits are not authorized as the clinical information submitted does not support the Michigan DCH Medicaid Guidelines under the medical necessity criteria. (Exhibit A. 12 & 13)
6. On ██████████ Appellant filed a hearing request appealing the denial. (Exhibit A.3)
7. Pursuant to additional internal reviews, on ██████████ and subsequently on ██████████ the MHP once again denied on the grounds that the medical necessity criteria is not met.
8. Appellant was eligible for chiropractic care again in ██████████.

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.

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*Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.*

As it says in the above Department - MHP contract language, a MHP such as CareSource 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 pertinent sections of the Medicaid Provider Manual criteria for prior authorization and Medical Necessity are below:

This chapter applies to Chiropractors.

1.1 MEDICAL NECESSITY

Determination of medical necessity and appropriateness of service is the responsibility of chiropractors within the scope of accepted medical practice and Medicaid limitations. Chiropractors are held responsible if excessive or unnecessary services are ordered, regardless of who actually renders these services (e.g., x-rays), or if reimbursement is received for the service. Chiropractors are subject to any corrective action related to these services, including recovery of funds.

1.2 BENEFICIARY COPAYMENT

A copayment of \$1 for each Medicaid reimbursable chiropractic visit may be required for beneficiaries age 21 years and older. When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single \$1 copayment may be charged to the beneficiary. When billing Medicaid for the service, chiropractors should bill their usual and customary (U&C) charge (i.e., without any adjustment for the copayment). Upon approval of the service, Michigan Department of Community Health (MDCH) automatically deducts the copayment. If the chiropractor deducts the copayment from the charge billed, an underpayment may result.

1.3 OTHER INSURANCE AND MEDICARE SERVICES

It is the chiropractor's responsibility to question the beneficiary regarding Medicare and other insurance coverage prior to providing the service. Medicaid is the payer of last resort. Payment must be sought from other third party payers before submitting claims to MDCH. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.4 NURSING FACILITY

Chiropractors may render manual spinal manipulations to beneficiaries in a NF as an ancillary service. The attending physician (MD or DO) must order all ancillary services, including chiropractic services. The chiropractor must keep and make available complete records of the services provided.

SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays. Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation. If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary. Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDCH Program Review Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis, including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and

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- Include any additional details, comments, etc. that may be of assistance in the evaluation.

The PA request is reviewed and a notice is returned to the provider stating the approval or denial of the request. If approved, the provider is notified of the number of additional visits granted. Providers are also given a PA number that must be placed in the PA field on the claim form when billing for the additional services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for claim completion instructions.)

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It is uncontested the MHP provided chiropractic services consistent with the coverage required by the Medicaid Provider Manual. It also made a determination of the medical necessity of additional visits in excess of those required to be provided. The MHP determined, based upon the documentation submitted, that the evidence did not support the “medically necessary” requirement to approve visits in excess of the 18 already used.

The determination was based upon the evidence that the beneficiary still had recurrent and chronic pain, and that the documentation does not show that further treatment would result in improvement. The MHP also indicated that medical necessity and covered care does not cover maintenance. Moreover, alternative pain therapy was not demonstrated.

The Appellant contested the determination on the grounds that the injuries are ■ years old and constitute “37 years of negligence.” Appellant did not offer credible and substantial evidence that would show that he meets the criteria required by federal and state law that would support finding that additional visits are medically necessary.

This ALJ finds that the MHP decision regarding their determination that the additional chiropractic visits are not medically necessary is supported by the substantial and credible evidence of record. Thus, the denial must be upheld.

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DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Department's denial of coverage for additional chiropractic visits in accord with the applicable portion of the Medicaid Provider Manual.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]

Date Signed: March 25, 2014

Date Mailed: March 27, 2014

***** 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.