

**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. 2014-15159 QHP

██████████

██████████

██████████

Appellant.

_____ /

DECISION AND ORDER

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

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Appeals Coordinator, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). Dr. ██████████, a Medical Director at the MHP, testified as a witness for Respondent.

ISSUE

Did the MHP properly deny Appellant's request for a Magnetic Resonance Imaging (MRI) of her lumbar spine?

FINDINGS OF FACT

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

1. Appellant is a ██████ year-old Medicaid beneficiary enrolled in the Respondent MHP. (Respondent's Exhibit A, page 14).
2. On or about ██████████, the MHP received a prior authorization request from a Dr. ██████████ for an MRI of Appellant's lumbar spine without contrast. (Respondent's Exhibit A, pages 14-16).
3. A New Patient Consult report from Dr. ██████████ was attached to that request. In that document, Dr. ██████████ wrote that Appellant reported a ██████ year history of low back pain; having stiffness in the mornings; being unable to sit for prolonged periods; taking Vicodin; and that the pain was increasing. (Respondent's Exhibit A, pages 15-16).

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4. The report also provided that Dr. ██████████ had recommended to Appellant that she quit smoking and start performing core strengthening exercises. (Respondent's Exhibit A, pages 15-16).
5. The report further provided that Appellant wanted an MRI performed, but that, unless it revealed significant findings, they would continue with a conservative report. (Respondent's Exhibit A, pages 15-16).
6. On ██████████, the MHP sent Appellant written notice that the request for a MRI was being denied. (Respondent's Exhibit A, pages 17-20).
7. Specifically, the denial stated that the request was being denied based on InterQual Imaging Criteria and that:

The test your doctor ordered 72148 MRI (Magnetic Resonance Imaging) of the Lumbar Spine without dye is not approved. A ██████████ ██████████ doctor looked to see if this test is needed and accepted rules were used. To have this covered you must meet the rules for MRI of the Lumbar Spine. The information we received shows that you have back pain but does not show a recent course of ██████████ weeks of medicine to reduce inflammation and special exercise such as physical therapy or home exercises has been tried. You do not meet the rules for this test. Please talk to the provider about health care options. The rules used for this decision were InterQual Guidelines,

Respondent's Exhibit A, page 17

8. On ██████████, the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, page 1).

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.

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In 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 and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

*MPM, October 1, 2013 version
Medicaid Health Plan Chapter, page 1
(Emphasis added by ALJ)*

The DCH-MHP contract provisions likewise provide that the MHP may limit services to those that are medically necessary pursuant to its own prior authorization requirements, utilization management or review criteria:

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E. Services

(1) Covered Services

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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.

* * *

AA. Utilization Management

- (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.

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- (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 . . .

*Contract No. 071B0200017, Print Version 1/23/2013
Article 1.020 Scope of [Services], pages 22-23, 55
(Emphasis added by ALJ)*

Here, the MHP reviews prior approval requests under the InterQual Imaging Criteria (Respondent's Exhibit A, pages 2-13) and, with respect to MRIs of the lumbar spine, those guidelines describe a number of clinical scenarios and the requirements for an MRI in each scenario. The MHP's Medical Director also testified that, in general and in situations where a patient's clinical presentation does not exactly match any clinical scenario, the criteria requires evidence of one-sided weakness; loss of reflexes upon examination; or the failure of at least three weeks of treatment with an anti-inflammatory medications and a home exercise program or physical therapy.

Based on the evidence presented, the MHP properly denied Appellant's request for an MRI of her lumbar spine based on InterQual Imaging Criteria. The evidence and documentation submitted in this case merely states that Appellant has a history of low back pain and there is no suggestion that Appellant meets any of the applicable criteria; has any one-sided weakness or loss of reflexes; or that Appellant has even tried any treatment without success. As such, the denial was proper.

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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for an MRI of the lumbar spine.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/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.