

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:

██████████

Appellant.

_____ /

Docket No. 2014-33306 QHP

██████████

██████████

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"). ██████████, a Medical Director at the MHP, testified as a witness for Respondent.

ISSUE

Did the MHP properly deny Appellant's requests for Magnetic Resonance Imaging (MRI) of her left shoulder?

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 9).
2. On or ██████████, the MHP received a prior authorization request made on behalf of Appellant from her physician and requesting a MRI of Appellant's left shoulder. (Respondent's Exhibit A, pages 9-18).
3. On the request form, the doctor indicated that Appellant had been diagnosed with shoulder pain. (Respondent's Exhibit A, page 9).
4. Medical records attached to the prior authorization requests also indicated that Appellant had been seen by the doctor on ██████████ for left shoulder pain, low back pain, and bilateral knee pain. (Respondent's Exhibit A, page 11).

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5. With respect to Appellant's shoulder pain, the documents attached to the prior authorization request also stated that Appellant had reported her shoulder pain had been constant and severe for three months and that her range of motion was decreased. (Respondent's Exhibit A, page 12).
6. The doctor also took an x-ray of Appellant's shoulder and that x-ray showed:

This shows no fracture, dislocation, or subluxation. All the joints are maintained. No evidence of degeneration at the acromioclavicular joint or glenohumeral joint. Overall this is an unremarkable left shoulder x-ray.

Respondent's Exhibit A, page 12

7. On ██████████, the MHP sent Appellant written notice that the request for a MRI was denied. (Respondent's Exhibit A, pages 19-23).
8. Specifically, the denial stated that the request was being denied based on InterQual Imaging Criteria and that:

This test 73221 MRI (Magnetic Resonance Imaging) of an Upper Extremity (arm) without dye is not approved. A ██████████ doctor used accepted rules (InterQual Guidelines) to see if this test is needed. You must meet the rules for MRI of the Shoulder. Information we received shows that you have shoulder pain but does not show physical therapy records showing that a recent course of at least four weeks of special exercises (physical therapy or home exercise) has been tried and has not helped. You do not meet the rules for this test. Please talk to the provider about health care options.

Respondent's Exhibit A, page 19

9. 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.

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

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services, excluded services, and prohibited services as set forth in the Contract.

*MPM, January 1, 2014 version
Medicaid Health Plan Chapter, page 1
(Emphasis added by ALJ)*

The MDCH-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:

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

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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 . . .

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 2-8) and, with respect to MRIs of the shoulder, those guidelines describe a number of clinical scenarios and the requirements for an MRI in each scenario.

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In particular, the MHP's witness testified that Clinical Scenario 1 of the Guidelines apply in this case and that the scenario requires (1) chronic shoulder complaints, unknown etiology; (2) two of the following symptoms: joint pain, locking, pain with range of motion, limited range of motion, tenderness, and crepitus; (3) an x-ray performed; (4) the x-ray diagnostic for etiology of symptoms or findings; (5) treatment during the course of illness or injury, including all of NSAIDS or acetaminophen, home exercises/physical therapy/occupational therapy for greater than five weeks and activity modification for greater than six weeks; (6) continued symptoms after treatment; and (7) MRI feasible. (Respondent's Exhibit A, pages 2-3).

Here, pursuant to those guidelines, the MHP denied Appellant's request for a MRI of left shoulder. The evidence and documentation submitted in this case generally provide that Appellant has shoulder pain and pain with range of motion, and that an x-ray was performed. However, there is no suggestion that Appellant meets all of the other criteria, including the requirement that more conservative treatment, such as NSAIDS/acetaminophen, home exercises/physical therapy or activity modification, have been attempted and have failed.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in deciding to deny her request. Moreover, this Administrative Law Judge is limited to reviewing the MHP's decisions in light of the information it had at the time it made those decisions.

In this case, given the information available at the time the MHP made the disputed decision, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the MHP erred and the decision to deny the prior authorization request must therefore be affirmed.

Appellant acknowledges that more conservative treatment has not yet been tried and, while the record documents her complaints of pain, those statements alone do not meet the criteria for approving the requested MRI. Appellant also indicated that she will speak to her doctor about other, more conservative treatment first.

To the extent Appellant obtains additional or updated information to regarding her medical condition or the treatment of that condition, she is free to have her doctor resubmit the request for a MRI, along all the relevant documents and information. However, with respect to the decision at issue in this case, the MHP's actions must be affirmed given the available information.

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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 a MRI of her left shoulder.

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.