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],

Docket No. 14-016559- MHP
Case No. [redacted]

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 telephone conference hearing was held [redacted]. Appellant appeared and testified on his own behalf.

[redacted], Inquiry Dispute Appeals Resolution Coordinator, represented Respondent [redacted] of Michigan, the Medicaid Health Plan ("MHP"). [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for a CT of his abdomen?

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 [redacted] year old male Medicaid beneficiary enrolled with [redacted] of Michigan. (Exhibit A, Testimony)

2. On [redacted], Appellant's physician sought prior approval for a CT of Appellant's abdomen based on a diagnosis of 564.1 and 789.00. (Exhibit A.16-17).

3. On [redacted] [redacted] of Michigan reviewed the request and issued a denial on the grounds that the information submitted does not show that the test request meets the InterQual Guidelines criteria. (Exhibit A.46-47).

4. On [redacted], the Michigan Administrative Hearing System received Appellant's hearing request stating in part: "…my CT scan was denied because my doctor needs to submit more evidence regarding treatment tried, testing completed and more detailed notes; these can be obtained and provided to validate my need for the CT scan…". (Exhibit A.2).

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.

The Respondent [redacted] submitted the InterQual Imaging Criteria for the abdomen, found on Exhibits A.19-45.

As noted above, an MHP such as [redacted] 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 and, is required to obtain verification to substantiate the necessity for the procedure. The process must be consistent with the Medicaid Provider Manual.

The QHP's Medical Director testified that Appellant's request for a CT of the abdomen was denied based on Inter Qual Imaging Criteria. (Exhibit A.19-45). The QHP's Medical Director testified that [redacted] could not determine why Appellant's doctor wants the CT-based on the evidence submitted. Appellant's physician indicated that Appellant has

'abdominal pain.' However, 'abdominal pain' in general is not specific enough. (Testimony). Moreover, the medical documents submitted by Appellant's physician basically show essentially a normal abdominal exam. (Exhibit A.12).

Appellant argued in his hearing request that "…more detailed notes can be obtained and provided to validate my need for the CT scan." (Exhibit A.2). However, at the administrative hearing, Appellant failed to submitt any evidence to support his claim.

Appellant has the burden of proof to establish eligibility. If Appellant believes that he has evidence that the criteria is met, federal and state law requires that the documentation be submitted before the CT of the abdomen can be approved. Appellant failed to submit evidence in support of his claim, including any evidence that would show that his doctor complied with the Inter OnterQual ciriteria.

Based on the evidence presented, the MHP properly denied Appellant's request for an CT of his lumbar spine based on InterQual Imaging Criteria. Here, the there was no such documentation submitted by Appellant's physician, contained with Appellant's hearing request, or, submitted at hearing. 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 a CT of his abdomen was proper.

IT IS THEREFORE ORDERED that:

The QHP's decision is AFFIRMED.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, 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.