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. 14-016819- 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 her own behalf.

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

ISSUES

1) Does Appellant have a right to a hearing regarding the MHP's non-payment to Appellant's physician for a service Appellant received?

2) Did the Department properly process the Appellant's prior-authorization request for the [redacted] epidural injection?

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 female beneficiary of the Medicaid program enrolled with [redacted] Care of Michigan. (Exhibit A, Testimony)

2. Appellant's relevant diagnosis lower back pain and radiculopathy. Appellant is [redacted] pounds with a BMI of 34.3/obese. (Exhibit A.7).

3. On [redacted] and subsequently on [redacted] Appellant had epidural injections for bilateral sacroliliac pain. Appellant's physician followed the [redacted] Guidelines and obtained prior approval (PA) for the

injections, not disputed herein. (Exhibit A.8;12).

4. On [redacted] Appellant received another injection. Appellant's physician did not obtain a PA for this injection but requested payment after the injection procedure was done. Appellant is not being billed by her physician for this service.

5. On [redacted] of Michigan issued a denial for the [redacted] injection based on the [redacted] Guidelines for Epidural Steroid Injections on the grounds that the documentation failed to show an 80% relief in pain for at least 8 weeks. (Exhibit A.25).

6. On [redacted], the Michigan Administrative Hearing System received Appellant's hearing request.

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.

Guidelines for [redacted] epidural injections state that in order to be eligible, PA is required. In addition, a maximum of 2 injections may be administered 2 weeks apart, and another only after 8 weeks following the second injection where the patient experiences 80% pain relief. (Exhibit A.22-24).

ISSUE (1)

The MHP motioned to deny jurisdiction for this administrative hearing on the grounds that the provider does not have a right to an administrative hearing under federal and state law. As noted in the Findings of Fact, the provider is not, in fact, requesting an administrative hearing. Rather, the member completed the hearing request, and, named the provider as an authorized hearing representative.

42 CFR Part 431 contains rights for a fair hearing:

> **§431.220 When a hearing is required.**
>
> (a) The State agency must grant an opportunity for a hearing to the following:
>
> (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.
>
> (2) Any beneficiary who requests it because he or she believes the agency has taken an action erroneously.
>
> (3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged.
>
> (4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.
>
> (5) Any MCO or PIHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.
>
> (6) Any PAHP enrollee who has an action as stated in this subpart.
>
> (7) Any enrollee who is entitled to a hearing under subpart B of part 438 of this chapter.
>
> (b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

As noted in 42 CFR 431.220, further reference must be made to subpart B part 43. CFR 42 438.400 states in part:

> **§438.400 Statutory basis and definitions.**
>
> (a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
>
> (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
>
> (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
>
> (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

Issue 1: The facts indicate that Appellant received the injection for which she filed an administrative hearing request. Appellant stated at hearing that her doctor asked her to file an appeal on the grounds that payment was not received. Appellant did not indicate that her physician was requesting payment of her, and, such would be violating federal law.

As noted above, Appellant does not have a right to a hearing to dispute a payment dispute between her physician and [redacted]. However, to the extent that Appellant requests a hearing on the grounds that a specific service was denied, the facts indicate that Appellant received the service, and, is not, and cannot be billed. Based on both of these sets of facts, Appellant has no right to a fair hearing. 42 CFR 431.220. To the extent that Appellant's hearing request fits under the general language of "a claim for service" the remaining decision herein will discuss the denial.

Issue 2: Regarding the [redacted] epidural, [redacted] presented evidence that the physician here failed to properly follow the PA procedures as required by the contract the Medicaid participating physician has with [redacted]. However, [redacted]'s evidence shows that even if the physician had done so, the injection would have been denied based on the [redacted] Guidelines for epidural steroid injections outline above. (Exhibit A.21-24).

For these reasons, and for the alternative reasons stated above, the MHP's actions herein are upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP's denial was proper.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

JS[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.