STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 15-003000-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 hearing was held [redacted]. Appellant appeared and testified on his own behalf.

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

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for an MRI of his neck and spine?

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

2. On [redacted], Appellant's physician sought prior approval for an MRI of Appellant's neck and spine. (Exhibit A, pp 4-7; Testimony)

3. [redacted] of Michigan reviewed the requested medical equipment and denied the request on [redacted], citing internal and Medicaid policy. A notice of the denial was mailed to Appellant on that same date. The notice included Appellant's right to a hearing. (Exhibit A, pp 16-20; Testimony)

4. 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. 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.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified.
> The covered services provided to enrollees under this Contract include, but are not limited to, the following:
>
> - Ambulance and other emergency medical transportation

- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids (only for enrollees under 21 years of age)
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services

- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21 [Article 1.020 Scope of [Services], at §1.022 E (1) contract, 1/23/2013, pp. 22-23].

* * *

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.
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. [Contract, *supra,* p. 55].

The contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior authorization request under InterQual Guidelines for MRIs of the neck and spine and denied the request because the documentation presented with the PA request did not meet the InterQual Guidelines for MRIs of the neck and spine.

The MHP's Medical Director testified that the InterQual Guidelines for MRIs of the neck and spine require documentation of NSAID or acetaminophen use for at least 3 weeks, activity modification for at least 6 weeks, or a home exercise program or physical therapy for at least 6 weeks. The MHP's Medical Director stated that the documentation showed that the Appellant had shoulder and neck pain, but it did not show NSAID or

acetaminophen use for at least 3 weeks, activity modification for at least 6 weeks, or a home exercise program or physical therapy for at least 6 weeks. The MHP's Medical Director stated MRIs should be delayed until the effect of conservative care, including physical therapy is determined. The MHP's Medical Director concluded that the Appellant's PA request did not meet the InterQual Guidelines for MRIs of the neck and spine.

Appellant testified this issue has been going on since [redacted]. Appellant described the pain as similar to the sensation one feels when hitting their funny bone, but that his sensation does not go away. Appellant indicated that it got to the point where he could not drive or ride in a car, so he sought medical treatment. Appellant indicated that he has had x-rays and went to physical therapy yesterday, but the physical therapist told him there was nothing they could do for him. Appellant indicated that he has tried some medications, but is also wary of taking some of the medications that have been prescribed for him. Appellant testified that if he and the MHP disagree about his care, he should be allowed to go elsewhere for treatment. Appellant testified that he felt like he was stuck with this MHP and that it was like a bad marriage. Appellant also expressed some concerns about the MHP which were outside of the scope of the instant hearing.

In response, the MHP's Medical Director informed Appellant that if he is unhappy with the MHP, he can switch health plans during the next open enrollment.

Appellant indicated that he thought the next open enrollment was in [redacted], but that he could not wait that long.

Based on the evidence presented, the MHP properly denied Appellant's request for an MRI of his neck and spine based on InterQual Imaging Criteria. As indicated above, InterQual Imaging Criteria requires evidence of NSAID or acetaminophen use for at least 3 weeks, activity modification for at least 6 weeks, or a home exercise program or physical therapy for at least 6 weeks. Here, there was no documentation of NSAID or acetaminophen use for at least 3 weeks, activity modification for at least 6 weeks, or a home exercise program or physical therapy for at least 6 weeks. If Appellant has since tried conservative treatment, and that treatment has failed, he can ask his doctor to document said care and resubmit a PA request. However, based on the information submitted with the original PA request, 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 an MRI of his neck and spine was supported by Medicaid Policy.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of
Health and Human Services

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.