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:

Docket No. 15-014009 MHP
Case No.

,

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 Appellant's request for a hearing.

After due notice, a four-way telephone conference hearing was held . Appellant appeared and testified on his own behalf.

Inquiry Dispute Appeals Coordinator, and appeared as witnesses on behalf of Molina Healthcare of Michigan, the Medicaid Health Plan ("MHP").

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for a CT of her cervical, lumbar, and thoracic 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 beneficiary of the welfare SSI and Medicaid programs enrolled with . (Exhibit A, Testimony).

2. On or about Appellant's primary physician sought prior approval for a CT of Appellant's spine. (Exhibit A, pp 7-20).

3. reviewed the request and issued a denial on on the grounds that the medical evidence submitted on Appellant's behalf does not meet the InterQual Guidelines that require evidence showing unequal reflexes or weakness on one side on exam; that a recent course of medicine to reduce inflammation and special exercise such as PT or home exercise has been tried; and does not show why an MRI cannot be done. (Exhibit A.129).

4. On the Michigan Administrative Hearing System received Appellant's hearing request. (Exhibit A, p 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.

As stated in the above Department - MHP contract language, an MHP such as Molina Health Care 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. The process is required to be consistent with the Medicaid Provider Manual.

The QHP's Medical Director testified that Appellant's request for a CT of the spine, all 3 views, was denied on the grounds that the evidence does not show unequal reflexes or weakness on one side of the exam; does not show a recent course of medicine to reduce inflammation and special exercise; and does not show why an MRI cannot be done.

As stated in her hearing request, as well as at the administrative hearing, Appellant stated that she cannot have an MRI as she has a heart pacer. The Respondent's witness agreed that a CT scan under these facts is more appropriate.
However, as to the remaining reasons, the Respondent's witness indicated that pursuant to Exhibit A.16, Appellant has no complaint of arm or neck pain.

Appellant pointed out that there was no evidence that the Respondent considered from the pain clinic with which Appellant had treatment(s). However, those records were not included and as pointed out by the Respondent, may very well suffice to meet the Inter Qual Criteria. The Respondent suggested that Appellant might want the pain clinic to resubmit the request with documentation to support the alternative therapies as required by the Inter Qual Criteria.

The purview of an administrative law judge (ALJ) is to review the Department's action and to make a determination if those actions are in compliance with Department policy, and not contrary to law. The ALJ must base the hearing decision on the preponderance of the evidence offered at the hearing or otherwise included in the record. The ALJ at an administrative hearing must base a decision upon the evidence of record focusing at the time of the assessment. The Department cannot be held accountable for evidence it was unaware of at the time of its determination

Applied to these facts, the physical therapy and home exercise program(s) was not evidence of record at the time of the MHP's determination. Nor can this ALJ take these factors into consideration as such is irrelevant under evidentiary legal requirements.

As indicated above, there was no evidence submitted by Appellant's physician to show that she met the criteria based on the available evidence. 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 the spine was proper based on the available evidence.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

cc:

Date Mailed:

***** 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.