STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 15-018504 MHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon Appellant's request for hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted] Paralegal, represented [redacted], the Respondent Medicaid Health Plan (MHP). [redacted] Chief Medical Officer, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for a spinal cord stimulator?

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 [redacted] year old Medicaid beneficiary, born [redacted] (Exhibit A, p 14; Testimony)

2. On [redacted], the MHP received a prior authorization request submitted on Appellant's behalf requesting a spinal cord stimulator. (Exhibit A, pp 11-25; Testimony)

3. On [redacted], the MHP sent Appellant written notice that the request for a spinal cord stimulator had been denied because, based on the included documentation, Appellant did not meet the criteria for a spinal cord stimulator. Specifically, the denial notice stated:

> You asked for a device to help your pain. It is called a spinal cord stimulator. Our rules tell us that this device has not been proven to be helpful unless you have certain problems. You have not had pain in your legs from severe and untreatable decreased blood

flow. You do not have a failed back syndrome from back surgery. You do not have complex regional pain syndrome. Your doctor did not tell us that you have one of these problems which are required by our rules. We cannot approve your request at this time. Our health plan rules for a spinal cord stimulator were not met.

(Exhibit A, p 6; Testimony)

4. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 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 services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services

- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)

- Vision services
- Well child/EPSDT for individuals under age 21

1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services (Refer to the Dental chapter of this manual for additional information.)
- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Maternal Infant Health Program (MIHP)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care

- Personal care or home help services
- Private Duty Nursing services
- *Services provided* to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
- Screening and assessment;
- Detoxification;
- Intensive outpatient counseling and other outpatient services; and
- Methadone treatment
- Transportation for services not covered by the MHP.

1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

Medicaid Provider Manual
Medicaid Health Plan Chapter
October 1, 2015, pp 1-3

When considering prior authorization requests for spinal cord stimulators, the MHP relies on criteria outlined in the Milliman Care Guidelines. Those guidelines state, in relevant part:

> Implanted electrical stimulator, spinal cord, may be indicated when **ALL** of the following are present:
>
> - Chronic neuropathic or ischemic pain, including **1 or more** of the following:
> - Complex regional pain syndrome (previously referred to as reflex sympathetic dystrophy)
> - Failed back surgery syndrome
> - Lower extremity pain at rest due to critical limb ischemia
> - Failed conservatire management, including **1 or more** of the following:
> - For limb ischemia, failed surgical or endovascular revascularization, or inoperable vascular disease
> - For neuropatic pain, stellate ganglion or lumbar sympathetic block
> - Pharmacotherapy
> - Physical therapy
> - Psychotherapy or cognitive behavioral therapy
> - Favorable psychological evaluation, absence of untreated psychiatric comorbidity, or current treatment in multidisciplinary pain management program
> - Improvement in pain to test stimulation of spinal cord
> - Patient capable of operating stimulating device
> - No cardiac pacemaker or implantable defibrillator
> - No coagulopathy, severe thrombocytopenia, or anticoagulant or antiplatelet therapy
> - No current or chronic infection
>
> *(Exhibit A, p 7,* ***emphasis in original****)*

The MHP's Medical Director testified that Appellant did not meet the criteria for a spinal cord stimulator because, based on the documentation submitted with the prior authorization request, Appellant did not have pain in her legs from severe and untreatable decreased blood flow (ischemia), failed back syndrome from back surgery, or complex regional pain syndrome.

Appellant testified that she does have pain in her leg all the way to her hip. Appellant indicated that she cannot even sleep or lay on her right side. Appellant indicated that she has extreme difficulty wearing socks and shoes due to the pain in her foot, ankle and leg. Appellant described the pain as similar to diabetic nerve pain. Appellant indicated that she has tried nerve blocks and all other options, but nothing has helped.

Appellant indicated that her toes are now curled and spread out, making it extremely difficult to even walk. Appellant indicated that the request was for a trial of the spinal cord stimulator, meaning that the stimulator would not be permanently implanted in her back during the trial. Appellant indicated that her doctor has told her that she meets all of the criteria for complex regional pain syndrome, except that her foot does not get hot. Appellant wondered if there was any way she could have her doctor submit more information.

In response, the MHP's representative indicated that they would have a case manager contact Appellant and possibly her doctor to see if more information was available, and then consider that information with regard to the criteria for a spinal cord stimulator.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request for the spinal cord stimulator. Given the record in this case, Appellant has failed to meet her burden of proof and the MHP's decision must be affirmed. As indicated above, in order to meet the criteria for a spinal cord stimulator, Appellant must have pain in her legs from severe and untreatable decreased blood flow, failed back syndrome from back surgery, or complex regional pain syndrome. Here, while Appellant does have pain, Appellant does not have pain due to any of the listed conditions. 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 MHP properly denied Appellant's prior authorization request for a spinal cord stimulator.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

Date Signed: [redacted]

Date Mailed: [redacted]

RJM/cg

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.