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. 15-020416 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 Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. Appellant appeared and testified.

[redacted], Inquiry Dispute Appeals Resolution Coordinator, represented [redacted], 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?

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.

2. On [redacted], Appellant's physician sought prior approval for an MRI of Appellant's back spine without dye.

3. On [redacted], [redacted] of Michigan reviewed the prior authorization with supporting documentation and denied the request 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.

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 (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 it says in the above Department - MHP contract language, a 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. The process must be consistent with the Medicaid Provider Manual.

Under the MHP contract provisions, an MHP may devise their own criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The MHP representative testified on the record that the information received does not show physical therapy records showing that a recent course of at least four weeks of special exercises has been completed and has not helped. MRI should be delayed until the effect of conservative treatment for this episode of pain has been determined.

The MHP's Medical Director indicated that Appellant's request for an MRI of the spine was denied because InterQual Imaging Criteria requires evidence of weakness, numbness, loss of reflexes or pain in a nerve root distribution, as well as failure of at least three weeks of anti-inflammatory medications and home exercise program or physical therapy before an MRI would be covered. Here, the MHP's Medical Director pointed out that there was no documentation of weakness, numbness, loss of reflexes or pain in a nerve root distribution nor was there documentation of recent physical therapy or a home exercise program.

Appellant testified that she just started physical therapy. Appellant indicated that he has constant back pain that is worsening.

Based on the evidence presented, the MHP properly denied Appellant's request for an MRI of the spine based on InterQual Imaging Criteria. As indicated above, InterQual Imaging Criteria requires evidence of weakness, numbness, loss of reflexes or pain in a nerve root distribution, as well as failure of at least three weeks of anti-inflammatory medications and home exercise program or physical therapy before an MRI would be covered. Here, there was no documentation of weakness, numbness, loss of reflexes or pain in a nerve root distribution nor was there documentation of recent physical therapy or a home exercise program. The MHP has established by the necessary, competent and substantial evidence on the record that it was acting in compliance with Department policy. 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 an MRI of the spine was supported by Medicaid Policy.

IT IS THEREFORE ORDERED that:

The QHP's decision is **AFFIRMED.**

Landis Y Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

[redacted]
Docket No. 15-020416 MHP
Decision and Order

LYL[redacted]

cc: [redacted]

Date Mailed: February 2, 2016

***** 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.