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. 15-018638-MHP

[redacted],

Appellant
_____________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 on [redacted]. Appellant appeared on his own behalf. [redacted], Assistant General Counsel, represented [redacted] the Medicaid Health Plan (MHP). [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for chiropractic manipulation under anesthesia?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who has been a member of MHP since [redacted]. (Exhibit A, pp 10, 12)

2. Appellant has a history of neck and back pain and he has been treated for these symptoms by [redacted]. (Exhibit A, pp 23-95; Testimony)

3. From [redacted] through at least [redacted] the Appellant had been treated for neck and back pain through manual adjustments to the cervical spine and lumbar region. The treatments reduced fixation and restored functional mobility. The Appellant responded positively to the treatments provided. (Exhibit A, pp 23-95; Testimony)

4. On or about [REDACTED], the MHP received a Prior Authorization Request from Appellant's doctor for a chiropractic manipulation under anesthesia. The request contained an MRI from [REDACTED] and visit notes from [REDACTED] through [REDACTED] (Exhibit A, pp 6, 12-95; Testimony)

5. On [REDACTED], the MHP advised Appellant and his doctor that the request was denied because the documentation received did not support that the requested procedure was medical necessary as the procedure was considered experimental. (Exhibit A, pp 97-105; Testimony)

6. On [REDACTED], the Appellant requested an external review of the [REDACTED] denial. (Exhibit A, p 5; Testimony)

7. On or around [REDACTED] the Medical Review Institute of America (MRIA) reviewed the Appellant's [REDACTED] request and the MHP's [REDACTED] denial. (Exhibit A, pp 106-111; Testimony)

8. On [REDACTED], the MRIA sent the MHP their findings regarding their external review. MRIA upheld the MHP's findings citing:

   > "Spinal manipulation under anesthesia is not supported by quality evidence of the management of spine-based neuromuscular filter conditions. The information does not establish that spinal manipulation under anesthesia will lead to decreased chronic pain. The submitted information and the reviewed literature does not establish that spinal manipulation under anesthesia will help to alleviate the patient's chronic pain. Given the lack of documentation and/or imaging suggesting the presence of deep tissue adhesions and/or scar tissue, spinal manipulation under anesthesia has no role in the treatment of the patient's condition. There is no role for the use of spinal manipulation under anesthesia for the treatment of spinal realignments." (Exhibit A, pp 106-111; Testimony)

9. On [REDACTED], the MHP sent the Appellant and the Appellant's requesting physician a second denial letter. The letter indicated:

   > "The services requested by your Doctor are not supported by quality evidence that shows it will help to lessen your chronic pain. There were no notes or images sent by your Doctor that show you have scar tissue, therefore this type of Chiropractic Service has no role in the treatment of your condition. This request does not support the [REDACTED]

> Medical Policy for Medical Necessity. Therefore, this request remains denied." (Exhibit A, pp 112-122; Testimony)

10. On , Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, pp 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.

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 MHPs.

The Respondent is one of those MHPs.

> 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. 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
- 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
- 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, 2010, p. 22].

(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 ███ decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *Supra,* p. 49].

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations."

With regard to medical necessity and non-covered services, MHP policy states, in part:

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- **Experimental/investigational drugs, biological agents, procedures, devices or equipment**

- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports

Medicaid Provider Manual
Providers Section
October 1, 2015, p 18.

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Appellant testified the denial was based upon a review of an MRI that was from ████ and that a more recent MRI would be more telling of his need for the requested service.

It was explained to the Appellant that I look at the snapshot in time in which the denial was made and the information that was made available to the MHP at the time of the decision.

In response, the MHP argued the only MRI produced with the request and during the review process was the ████ MRI. The MHP also argued the requested service was investigational and experimental in nature and as a result was properly denied.

The MHP based there decision on the medical records produced, the request itself and medical literature regarding the requested service.

Based upon the evidence produced, I find the Appellant has failed to prove, by a preponderance of the evidence, that the MHP improperly denied the requested service. The evidence indicates the requested service was investigational and experimental in nature as the MRI does not indicate a fracture or dislocation that needs immediate manipulation nor will the requested procedure alleviate the Appellant's chronic pain.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of Appellant's request for chiropractic manipulation under anesthesia is affirmed.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Corey A. Arendt
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed:

Date Mailed:

CAA/db

cc:

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.