RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: April 5, 2016
MAHS Docket No.: 16-000019
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. Petitioner appeared on behalf of the Petitioner. [redacted], Lead, Grievance and Appeals, of [redacted], represented the Medicaid Health Plan (MHP or Respondent).

Respondent's Exhibit A pages 1-46 were admitted as evidence.

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for Prior Authorization for consultation with an orthopedic surgeon?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. [redacted] is a qualified health plan contracted with the State of Michigan Comprehensive Health Care Program.

2. Petitioner was an enrolled member with [redacted] at the time of the request for services and continues to be enrolled.

3. The [redacted] Healthy Michigan Plan Member Handbook and Certificate of Coverage were sent at the time of enrollment. The Member Handbook outlines coverage limitations, prior authorization requirements, limitations and exclusions, and the pharmacy guidelines.

4. On [redacted], Dr. [redacted], family practice, submitted a Prior Authorization form and clinical records to [redacted] for a consultation with an orthopedic surgeon, Dr. [redacted]. (Attachment B)

5. On [redacted], upon review of the information provided, the request for coverage was denied and notice was sent to Petitioner, Dr. [redacted] and Dr. [redacted]. (Attachment C)

6. The request was denied based on [redacted] Medical Policy No. 91531-R2 [redacted] (Attachment D), which indicates evaluation by a [redacted] (COE) is required prior to referral to an orthopedic or neurosurgeon fro back or neck care unless there is acute indication for surgical evaluation. This policy further states that an acute indication may be evidence of tumor, infection or fracture, acute weakness for both arms or legs associated with upper motor neuron signs, loss of bladder or bowel control and/or cord compression with decreased T1 signal changes at multiple cord levels on MRI, or cauda equine syndrome.

7. Information reviewed shows Petitioner has symptoms of right-sided pain and thigh pain, but it does not show an acute indication. Therefore, the requested surgical consultation is not covered at this time.

8. The [redacted] Healthy Michigan Plan Member Handbook and Certificated of coverage Section 2 – Obtaining Covered Services – C. Referral, A Second Medical Opinion (Attachment E), states "We may also require a second opinion from a Specialist that we have chosen. This required second opinion will be used to assist us in determining whether services or supplies are medically/clinically necessary according to our medical and behavioral health policies or adopted criteria.

9. Review of [redacted]'s medical claims processing system, FACETS, indicates Petitioner's last two appointments with Dr. [redacted] were on [redacted] and [redacted] (Attachment F).

10. On [redacted], the Michigan Administrative Hearing system received a Request for Hearing from Petitioner.

11. On [redacted], [redacted] received a Request for Hearing from the Michigan Administrative Hearing System stating: "Dr. [redacted] did both my neck and back surgery. I need to go back to him."

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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. Contractors 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 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDHHS contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management

> 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004.*

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:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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. 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."

Under the (MDHHS)-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.

Petitioner testified that in her opinion it is a waste of time to go to see other doctors when she could just go to see the doctor who performed the prior surgery.

The evidence on the record indicates that the request was denied based on Priority Health Medical Policy No. 91531-R2 [redacted] (Attachment D), which indicates evaluation by a [redacted] (COE) is required prior to referral to an orthopedic or neurosurgeon fro back or neck care unless there is acute indication for surgical evaluation. This policy further states that an acute indication may be evidence of tumor, infection or fracture, acute weakness for both arms or legs associated with upper motor neuron signs, loss of bladder or bowel control and/or cord compression with decreased T1 signal changes at multiple cord levels on MRI, or cauda equine syndrome.

Further, information reviewed shows Petitioner has symptoms of right-sided pain and thigh pain, but it does not show an acute indication.

The [redacted] Healthy Michigan Plan Member Handbook and Certificated of coverage Section 2 – Obtaining Covered Services – C. Referral, A Second Medical Opinion (Attachment E), states "We may also require a second opinion from a Specialist that we have chosen. This required second opinion will be used to assist us in determining whether services or supplies are medically/clinically necessary according to our medical and behavioral health policies or adopted criteria

In the instant case, the Medicaid Health Plan (MHP) does not have discretion to approve Petitioner's request for items when insufficient evidence in support of medical necessity has been provided. Petitioner's physician may resubmit a Prior Authorization request for surgery consultation with the appropriate documentation or Petitioner can followed the appropriate steps outlined for authorization of such a request and the MHP will be able to consider the request. The decision to deny the request for authorization must be upheld under the circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the MHP's denial of Petitioner's request for a consultation with an orthopedic surgeon was proper under the circumstances.

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

LL/[redacted]

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[redacted]

Community Health Rep

[redacted]

Petitioner

[redacted]