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.: 16-000207
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], Appeals Coordinator; and Dr. [redacted], Medical Director, represented [redacted] of Michigan, the Medicaid Health Plan (MHP or Aetna or Respondent).

Respondent's Exhibit a pages 1-39 were admitted as evidence.

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for an MRI Lower Extremity?

FINDINGS OF FACT

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

1. Aetna (MHP) is contracted with the State of Michigan to arrange for the delivery of health services to Medicaid recipients.

2. EviCore, (previously MedSolutions), is contracted with Aetna to process requests for radiological testing.

3. At all times relevant to this case, Petitioner was enrolled in the MHP.

4. On [redacted], Evicore received a Prior Authorization request from the office of Dr. [redacted], MD, requesting authorization to perform CPT

procedure 73721 (MRI Lower Extremity, any joint, without contrast materials(s)).

5. On [redacted], the request was approved with an expiration date of [redacted].

6. On [redacted], Petitioner was scheduled for an MRI.

7. Petitioner cancelled the appointment and did not receive the MRI.

8. No claims were submitted for the services and the request expired.

9. On [redacted], Evicore received a second request from the office of Dr. [redacted] to perform CPT Procedure 73721.

10. On [redacted], this case ([redacted]) was approved with an expiration date of [redacted].

11. No claim was submitted for this service.

12. On [redacted], Evicore received a third request from the Office of Dr. [redacted], MD requesting authorization for CPT Procedure 73721.

13. The [redacted] request ([redacted]) was denied stating that a concurrent prior authorization of a similar study is on file and in effect until [redacted].

14. On [redacted], Evicore received a fourth request from the Office of [redacted], MD, requesting authorization to perform CPT Procedure 73721.

15. The case ([redacted]) was denied stating, "Evicore Imaging guidelines do not support imaging for the clinical indication(s) presented. The previous imaging study performed could be sufficient for the evaluation of the clinical condition. Based on the clinical information provided, additional imaging should not be necessary at this time. Therefore, the requested imaging is not approved."

16. On [redacted], Petitioner filed a Request for Hearing with the Michigan Administrative Hearing system to contest the denial of her prior authorization requests.

17. As Evicore is only contracted to handle prior authorization requests and has no access to claims data, the company would have no way of knowing

whether or not the member actually had the test(s) that are being requested.

18. On [redacted], [redacted]'s Grievance and Appeals Department receive notice that Petitioner had requested an Administrative Fair Hearing regarding the requested services.

19. On [redacted], per CHAMPS, Petitioner's coverage with [redacted] was terminated on [redacted]. Petitioner was enrolled in [redacted] effective [redacted].

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 (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. 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.*

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.

In the instant case, Petitioner's Medical Doctor requested prior authorization for MRI testing for Petitioner. The request was approved twice. Petitioner cancelled the first appointment for an MRI and no subsequent MRI was set up for her by her physician. [redacted] approved two different prior authorization requests by Petitioner's physician. The MHP contract agency is only contracted to handle prior-authorization requests. The

agency would have no way of knowing if the member has actually had the service performed. Thus, the MHP properly denied the third prior authorization requests as there was a prior request still active that had not been utilized. However, Petitioner's physician filed a fourth prior authorization request for the MRI on [redacted]. The prior authorization request had expired and the MHP had not been billed for the MRI. The sequence of events effectively denied the Petitioner medically necessary services.

Appellant has failed to satisfy the burden of proving by a preponderance of the evidence that the MHP improperly denied the requested MRI. The [redacted] decision to deny the request for prior authorization cannot 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 [redacted] denial of Petitioner's Prior authorization request for an MRI of the lower extremity without dye was improper under the circumstances.

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan's decision is **REVERSED**. The MHP is **ORDERED** to reinstate Petitioner's [redacted] prior authorization request for MRI and if Petitioner is otherwise eligible authorize approval and subsequent payment for the MRI.

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]

Authorized Hearing Rep. [redacted]