BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
L D	)	OAH No. 17-0072-MDX
	)	Agency No.

DECISION

I. Introduction

L D is a Medicaid recipient. Mr. D's physician requested that the Medicaid program provide him with authorization for an MRI of his lumbar spine. The Division of Health Care Services (Division) denied the request.[1] Mr. D requested a hearing.[2]

Mr. D's hearing was held on February 15, 2017. Mr. D represented himself and testified on his own behalf. Angela Ybarra represented the Division. Sherri Larue, a Division medical assistance administrator, testified on the Division's behalf.

The record indicates that Mr. D's medical provider did not provide sufficient evidence to establish that a lumbar spine MRI is medically necessary for Mr. D. Therefore, the Division's decision denying prior authorization is upheld.

II. Facts

At the hearing, Mr. D explained that he had previously had a cervical spine MRI, followed by surgery on the cervical area of his back, both of which were paid for by Medicaid. After recovering from that surgery, he experienced significant pain in the lumbar area. In late December 2016, his physician referred him for a lumbar MRI. After a waiting period of about a week, he was told by the medical provider's staff that he had been approved for the MRI.[3] On January 6, 2017, the provider performed the MRI procedure. Subsequently, Mr. D learned that the Division, through its contractor Qualis Health, had denied authorization for the procedure. The denial was apparently issued on January 12, 2017.[4] Mr. D then filed this appeal.

Ms. Larue explained that Qualis denied authorization because the records provided by Mr. D's medical provider to the Division did not establish medical necessity for the MRI procedure. She testified regarding those records and about Qualis's review and analysis of them.

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1 Exhibit D.
2 Exhibit C.
3 D testimony.
4 *See* Exhibit E3.

The records show that Mr. D met with his medical provider regarding his back pain on December 28, 2016; the physician wrote "[g]iven the chronic complaint of low back pain, I will send him for an MRI of his lumbar spine."[5] The request for pre-authorization, however, was not received by Qualis until January 4 or January 5, 2017.[6] Qualis then evaluated the supporting documentation and requested additional backup from the provider. The provider provided no additional information, other than to clarify on January 6, 2017 that the request was for a lumbar MRI, rather than another cervical spine MRI.[7] Qualis then reached the conclusion that the request should be denied; the records indicate that Qualis reached that conclusion on January 12, 2017.[8] The denial was based on Qualis's application of "InterQual criteria," which Ms. Larue described as national standards used to evaluate medical necessity for "high dollar procedures."[9] Qualis's denial rationale was described in the records as follows:

> [T]he patient has nonspecific low back pain and no neurologic deficits. In addition, there is no documented suspicion of malignancy, deep seated infection or cauda equina syndrome[10] and the patient does not have evidence of lumbar radiculopathy.[11]

Ms. Larue testified that these examples listed by Qualis are among the InterQual criteria for approval of MRIs. She also pointed out that after concluding the request should be denied, Qualis contacted the medical provider to invite them to engage in a "doc to doc" dialogue, where Mr. D's physician would be able to speak with a physician at Qualis to discuss the basis for the denial and have Qualis essentially conduct a second level review of the decision. Mr. D's medical provider never responded to this invitation, according to Ms. Larue.[12]

The documents in the record established that Mr. D had previously received a lumbar spine MRI in October 2013, and Qualis was provided records relating to that MRI.[13] Those records show Mr. D's provider recorded the following "impression" from the MRI at that time:

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[5] Exhibit E12.

[6] *See* Exhibits E2, E4.

[7] Exhibit E3.

[8] Exhibits E3. *See also* exhibits E2, F1, which respectively indicate the denial decision may have been reached on January 9 or January 11, 2017.

[9] Larue testimony. Ms. Larue stated that the Division would supplement the record after the hearing with the pertinent InterQual criteria, but that did not occur.

[10] Cauda equina syndrome is a serious neurologic condition resulting in loss of function of the nerve roots in the lumbar area. Larue testimony.

[11] Exhibit E3.

[12] Larue testimony.

[13] *See* exhibits E9, E29; Larue testimony.

1. Broad-based disc bulges at L4-5 and L5-S1 without neural foramina or central canal compromise.
2. Scoliosis.
3. Mild to moderate facet joint degenerative changes at L4-5 with mild facet joint degenerative changes at L5-S1.[14]

The October 2013 MRI is also mentioned in notes from Mr. D's provider dated May 25, 2016, where it is stated that the MRI was reviewed and that it "shows no significant disc desiccation, central canal stenosis or neural foraminal stenosis to any degree," adding that "[n]o gross abnormalities noted."[15] The current provider stated her assessment on that date as "chronic low back pain with no significant lumbar spine etiology."[16]

Ms. Larue explained that the 2013 MRI was more than three years old at the time that pre-authorization was requested for Mr. D's lumbar MRI, and that records that old are generally given very little weight in determining medical necessity. Because of that, Qualis both sought additional information from Mr. D's medical provider and invited the "doc to doc" dialogue with the provider. No additional information was provided, and the "doc to doc" discussion never took place.

Ms. Larue also testified regarding the proper sequence and timeframes that medical providers and Qualis must follow regarding pre-authorization requests. She explained that under its contract with the Division, Qualis has 72 hours to reach a decision on a request after it has received all supporting documentation from the medical provider. In this case, Qualis had received all of the provider's information by January 6, 2017; but according to Ms. Larue's explanation of the records, Qualis apparently did not enter its denial decision until January 12, 2017. Qualis therefore did not meet its 72-hour deadline in processing this pre-authorization request.

Ms. Larue also pointed out, however, that medical providers are aware of and understand the Qualis approval process, including the 72-hour timeframe for reaching a decision. In this case, the provider submitted the request for pre-authorization on either January 4 or January 5, 2017, and then proceeded to perform the MRI on Mr. D on January 6, 2017, without waiting for approval. Thus, the procedure had already been performed before Qualis's 72-hour decision timeframe had even elapsed. Ms. Larue and Ms. Ybarra both opined that under these

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[14] Exhibit E29.
[15] Exhibit E9.
[16] *Id.* Etiology is another term for cause or origin.

circumstances, Division regulations would prohibit the provider from requiring Mr. D to pay for the procedure (if the Medicaid denial were to be upheld in this appeal).

Mr. D testified that prior to the hearing he had contacted his medical provider's billing staff and was told that their records indicate that he owed them nothing for the MRI procedure. The hearing was held on February 15, 2017, after which the record was kept open for two weeks to allow the Division to submit additional records from Qualis. During that period, the Division submitted its Exhibit F, which is essentially a compendium of Qualis's notes and analysis leading to the denial decision. A status conference was held on March 3, 2017, to confirm whether either party wished to present additional testimony. The only additional testimony offered was Mr. D's comment that he had contacted his medical provider's billing department again; they informed him that they were waiting on the results of this appeal, and if the appeal were denied, they would likely send him a bill for the cost of the MRI procedure. Ms. Ybarra then advised Mr. D that if his provider does attempt to bill him, Division staff will assist him in communicating with the provider regarding the regulations that limit their ability to make him pay for this MRI procedure.

III. Discussion

Mr. D has the burden of proving, by a preponderance of the evidence, that the Division's denial of pre-authorization for his lumbar MRI was incorrect. The Division's position is that Mr. D and his medical provider did not adequately demonstrate the medical necessity for the MRI procedure. Mr. D argues that he is experiencing ongoing, debilitating low-back pain, and the procedure was needed to attempt to determine the source or cause of that pain.

The Alaska Medicaid program requires prior authorization for the MRI procedure.[17] Authorization can only be approved if the procedure is medically necessary. Neither the federal Medicaid Act nor the accompanying federal regulations define medical necessity. The responsibility for defining medical necessity is left to each state.[18] Alaska regulations and statutes also do not contain a broad definition that sets out when procedures of this type are medically necessary. The pertinent portions of the applicable Alaska regulation, 7 AAC 105.110, simply state that Medicaid "will not pay for a service that is (1) not reasonably necessary for the diagnosis and treatment of an illness or injury … as determined upon review by

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[17] 7 AAC 105.100(6), 7 AAC 105.130(a)(10).

[18] *See Thie v. Davis*, 688 N.E.2d 182 (Ind.App.1997).

the department," or "(2) not … medically necessary in accordance with criteria established under [Department regulations] or by standards of practice applicable to the prescribing provider."[19]

In order to apply these general standards to specific procedures such as Mr. D's lumbar MRI, the Division and Qualis use the InterQual criteria in analyzing medical necessity issues. Those criteria required that Mr. D's physician provide more recent information than the three-year old MRI from 2013. In addition, even the information related to the 2013 MRI was equivocal. On one hand, the MRI impressions written in 2013 indicated certain problems such as "broad-based disc bulges" and "mild to moderate facet joint degenerative changes." On the other hand, Mr. D's own physician in 2016 wrote that the 2013 MRI showed "no significant disc desiccation, central canal stenosis or neural foraminal stenosis to any degree" and "no gross abnormalities" in the lumbar area.

In general, more weight is given to a treating physician's opinion than the opinions of those who do not treat a claimant.[20] An examining physician's opinion is "entitled to greater weight than the opinion of a nonexamining physician."[21] In this case, however, the most relevant, recent information from Mr. D's physician was the May 2016 commentary regarding the 2013 MRI. Faced with this equivocal evidence, Qualis was justified in seeking additional information to evaluate the pre-authorization request. Qualis communicated with Mr. D's provider and offered the opportunity for a "doc to doc" discussion, which would also have been an opportunity to provide more up to date information in support of the request for authorization for the lumbar MRI. The provider failed to respond or to provide any additional information. Thus, Qualis had to base its authorization decision on the equivocal information related to the 2013 MRI, and Mr. D's general complaints regarding low back pain. This was insufficient information on which to find that the MRI was medically necessary.

Based on the foregoing, Mr. D did not meet his burden of proving by a preponderance of the evidence that the Division's denial of authorization was done in error.

However, because the provider performed the MRI procedure before the Division and Qualis had issued a decision on the pre-authorization request, the provider is probably barred

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19 7 AAC 105.110(1), (2).

20 *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1996).

21 *Id.*

from requiring payment from Mr. D for the procedure.[22] Ms. Larue or other Division staff should be available to assist Mr. D in addressing any disagreement with his provider on this issue.

IV. Conclusion

Mr. D did not meet his burden of establishing that his provider adequately demonstrated medical necessity for his lumbar MRI. Therefore, the Division's decision to deny his prior authorization request for that procedure is UPHELD.

DATED this 17th day of April, 2017.

Signed
Andrew Lebo
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 2nd day of May, 2017.

By: *Signed*
Name: Andrew M. Lebo
Title: Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]

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22 *See* 7 AAC 145.005(d) "conditions for payment" ("when a provider furnishes a covered service to a recipient who, before receiving the service, has furnished the provider with a recipient identification card … or other evidence of Medicaid eligibility, the recipient is under no obligation to pay the provider for the service … .").