**BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH**

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| In the Matter of | ) | |
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| U. S. | ) | OAH No. 24-0302-MDX |
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# DECISION

## I. Introduction

U. S. receives Medicaid benefits from the State of Alaska. She requested preauthorization for a magnetic resonance angiogram (MRA) of her head and neck. After the Division of Health Care Services (Division) denied the request as not medically necessary, Ms. S. requested a hearing to challenge the denial.

The hearing began on June 13, 2024 and continued on June 28, 2024. Ms. S. represented herself in the hearing and testified on her own behalf. Her physician, Dr. H. T., also testified. Fair Hearing Representative Laura Baldwin represented the Division. Dr. F. U., a reviewing physician with Comagine Health, testified for the Division.

Because Dr. T. testified that that an MRA is unlikely to yield information useful for diagnosing or treating Ms. S. currently, there is no dispute that an MRA is currently unnecessary, and the preauthorization request for an MRA is now moot. Accordingly, the request for preauthorization of an MRA is dismissed, and the Division's denial of the request is affirmed.

## II. Facts

### *A. Preauthorization Request*

Ms. S. is a 47-year-old Medicaid recipient who has experienced a variety of health problems since contracting the Covid-19 virus multiple times.[1] On April 1, 2024, her physician, Dr. H. T. with the Clinic, submitted a request for prior authorization from the Medicaid program for magnetic resonance imaging (MRI) of the brain stem, a neck and cervical spine MRI, and a head and neck MRA for Ms. S.[2] The supporting documentation included notes of Ms. S.'s telehealth appointments with Dr.

T. on February 2, 2024 and March 27, 2024, which reference a multitude of symptoms, including a drooping face, hand and foot numbness and tingling, intermittent migraines, memory

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1 Ms. S.'s testimony.

2 Ex. A, p. 2.

issues, a sore neck, and bladder control problems.[3] Dr. T.'s notes of the first appointment indicate that Ms. S. saw a neurologist or vascular surgeon at Hospital A. who thought she had long-Covid, but notes of the second appointment state that she did not actually see a doctor there.[4] Dr. T. also documented in his notes of the second appoint, "Last time I was worried she might have had a stroke. She refused to go to ER."[5]

### *B. Review of Preauthorization Request*

The preauthorization request was reviewed by Comagine Health, a quality improvement organization that conducts preauthorization reviews of various medical procedures on behalf of the Division.[6] In evaluating a preauthorization request, Comagine gathers information from a patient's health care provider and uses a tiered decision-making process and a risk-benefit analysis to determine the appropriateness of requested services for the patient.[7]

Pursuant to its internal review procedures, Comagine sent the preauthorization request to a nurse reviewer on April 19, 2024, for a determination of the medical necessity of the two MRIs and the MRA.[8] The nurse determined that the procedures were not medically necessary, based on her application of the InterQual criteria, which Dr. U. described as national standards for evaluating medical necessity.[9] Those criteria for an MRA include suspected ischemic stroke, ischemic stroke by imagining, new or worsening central nervous system (CNS) symptoms or findings, and planned endovascular intervention or follow-up to prior intervention.[10]

Next, the matter was submitted to a first-level physician reviewer with Comagine on April 22, 2024.[11] Noting that "[n]o physical exam has been performed," and "[n]o ER evaluation has occurred for active episode," the reviewing doctor documented that Ms. S.'s symptoms:

> . . . do not clearly follow a vascular neurological distribution to suggest ischemic stroke. The documentation provided references diagnoses of neuropathy and chronic foot spasms as well as past episodes of "right sided weakness/TIA/tremors when tired." She had been evaluated at Vanderbilt for the latter symptoms, though it is unclear what that

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3 Ex. F, pp. 6-7, 12-14. The notes also reference her seeing a neurologist or vascular surgeon at Hospital A. who thought she had long-Covid, but they later she testified that she did not actually see a doctor there.) Also show that she refused to go to ER.

4 Ex. F, pp. 7 and 12.

5 Ex. F, p. 12.

6 Dr. U.'s testimony.

7 Dr. U. explained in his testimony that the goal is ensure that the "right care" is provided to the patient "for the right circumstances at the right time."

8 Ex. E, p. 7.

9 Ex. E, p. pp. 8-9; Dr. U.'s testimony.

10 Ex. E, p. pp. 8-9; Dr. U.'s testimony.

11 Ex. E, pp. 2-4.

> evaluation included; notes provided state that their impression was neurological sequelae of long-COVID rather than discrete cerebrovascular disease.[12]

Finding that the InterQual guidelines were not met, and that "no compelling clinical rationale" existed for an exception to the guidelines, the doctor concluded that neither the MRIs nor the MRA were medically necessary.[13] The doctor also identified questions, the answers to which could help inform the evaluation of the preauthorization request. The questions included whether there is information that supports a cerebrovascular cause of Ms. S.'s symptoms and what the neurologist at Hospital A. determined.[14]

On April 29, 2024, a Comagine doctor spoke with Dr. T. for a peer-to-peer, "doc-to- doc" discussion.[15] Based on that discussion, the Comagine doctor recommended overturning the prior denial of the two MRIs, noting Dr. T.'s concern that a brain MRI could rule out possible multiple sclerosis, and that many neurologists would not see Ms. S. until MRIs of the brain and cervical spine were done first.[16] Regarding the head and neck MRA, however, the Comagine doctor reached a different conclusion:

> . . . given the invasive nature of the test, and no recent in person physical exam evaluation, the provider agreed on holding off on this test and depending on what the other tests show, and if a neurologist or vascular provider were to agree, the [MRA] could be done at a later time. Given there are no compelling reasons to make an exception to the [InterQual] guidelines for this test, recommend upholding the prior denial. [17]

Accordingly, on April 29, 2024, the Division denied authorization for the MRA as not medically necessary at that time. Ms. S. requested a hearing on the Division's decision.[18]

The matter was subsequently referred to a specialty-matched review by a Board-certified neurologist with Comagine regarding the medical necessity of an MRA.[19] Notes from the neurologist's review, which was conducted on June 26, 2024, reiterated the findings from the earlier steps in the review process:

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12 Ex. E, p. 2.
13 Ex. E, p. 2.
14 Ex. E, p. 4.
15 Ex. E, pp. 1-2.
16 Ex. E, p. 1.
17 Ex. E, pp. 1-2. Dr. T. clarified at the hearing that he did agree an MRA was not medically necessary at that time; he agreed to do the MRIs and have the MRA put on hold for the time being. Dr. T.'s testimony.
18 Ex. C.
19 Exs. G and H.

> InterQual criteria for an MRA are not met due to a lack of clear history of symptoms that could reasonably be attributed to ischemia in a specific artery and the greater likelihood of another explanation (e.g., multiple sclerosis (MS) or a non-neurological cause.) There is no compelling clinical rational for deviating from established imagine guidelines as the history suggests multiple symptoms that would not likely be explained by ischemia (loss of bladder control, right and left-hand alternating symptoms, memory difficulties). A diagnosis of MS is under consideration. That condition might more durably explain the symptoms and would not require vascular imagine; brain magnetic resonance imagining (MRI) is the imaging test of choice in the diagnosis of MS. Brain MRI has been approved, which is also highly sensitive and specific for stroke. If a recent stroke in a specific vascular territory is identified on brain MRI, MRA of head and neck may then be indicated. The MRA head and neck are not medically necessary at this point in the patient's investigation.[20]

### *C. Hearing*

There was detailed testimony at the hearing about numerous topics, including the results of the MRIs, which were done on May 19, 2024 (after the date of the Division's April 29, 2024 decision to deny preauthorizing an MRA).[21] Ms. Baldwin clarified that the Division's April 29, 2024 decision to deny the MRA must be evaluated based on the information available at that time, but the Division was willing to review the MRI reports, in case they might cause the Division to conclude that an MRA is medically necessary currently. Nevertheless, Dr. U. testified that the new MRI results do not change his view on the necessity of an MRA. He described an MRI as "highly sensitive and specific" for a stroke; thus, if a stroke is identified on an MRI, an MRA of the head and neck may be indicated.[22] In this case, however, Dr. U. said the MRIs show no evidence of a stroke (neither MRI report "show[s] a specific lesion that would be consistent with stroke or ischemia or blood support of MS", "no evidence of gray matter heterotopia, cortical dysplasia, or vascular malformation" to indicate a blood supply problem, no "abnormal hemosiderin" evidencing prior bleeding may have occurred previously, and no "restricted fusion" evidencing a reduced blood flow."[23]

Dr. T. expressed frustration about the Medicaid approval process and what he considers to be unconscionable delay in getting services approved.[24] He offered his view that an

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20 Ex. G, p. 1; Ex. H, p. 2.
21 Exs. I and J; Dr. Raman's testimony, Ms. S.'s testimony, Dr. T.'s testimony.
22 Dr. U.'s testimony.
23 Dr. U.'s testimony.
24 Dr. T.'s testimony.

MRA would have been helpful when Ms. S. first came to him with worsening symptoms, to determine whether she may have had a small stroke or aneurism.[25] But he agreed that an MRA would be of limited utility at this juncture, stating:

> I don't think that the MRA at this stage in the game is probably going to be very helpful. Not impossible that it would help, but it's probably not going to be helpful three months out to help her make a decision as to whether she had a small aneurism. . . Her worsening symptoms really led me to believe that I needed an MRA, really, within the first 24-hours. . . [26]

He reiterated this point later in his testimony:

> I think the probabilities. . . in the immediate timeframe around the time of when she was having worsening symptoms, was the ideal time to do this test to figure out what was going on and whether she had an aneurism or not, or whether she had some small strokes or not or arterial ischemia, you might say, that doesn't show up. That was the time to really do these to look at that. Can it provide information now? A little bit maybe, but the probabilities are low that an MRA at this time is going to show something I can do something about. Not zero. And so the question is how many stones do we turn over, and how expensive are those. In my opinion, I don't think an MRA would have a high likelihood of giving us something that's going to change my ability to treat her. So it's kind of past its time of usefulness. In medicine, we say time is the best teller of what's going on.[27]

Nevertheless, Dr. T. and Ms. S. believed it would be beneficial for Ms. S. to have the Division preapprove an MRA, in the event she has acute incident suggestive of a stroke in the future, to avoid the delays associated with the review and appeal process.[28] Dr. U. responded that Comagine "tr[ies] not to do just standing orders for things that may come up. It's really tied to the right procedure for the right patient at the right time." He added that "there are times when a decision needs to be made urgently about a specific study or procedures. That's what the emergency room is for. This process, I have to make clear, is not designed for something where there's a life or death or high morbidity decision that has to be made on the order of minutes or hours. That's what the emergency room is. That is not what this process is for."[29]

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25 Dr. T.'s testimony.
26 Dr. T.'s testimony.
27 Dr. T.'s testimony.
28 Ms. S.'s testimony and Dr. T.'s testimony.
29 Dr. U.'s testimony.

## III. Discussion

In reviewing the denial of the request for an MRA here, the original question was whether Ms. S. has met her burden of proving that the MRA was medically necessary. The Alaska Medicaid program requires prior authorization for various medical services, including MRAs.[30] Alaska Medicaid regulations explicitly state that Medicaid will only pay for services that are medically necessary – not those that are: (1) not reasonably necessary for the diagnosis and treatment of an illness or injury as determined upon review by the Department, or (2) not medically necessary in accordance with criteria established under the Department regulations or by standards of practice applicable to the prescribing provider.[31]

It is unnecessary to answer that question, however, because Ms. S.'s claim for an MRA is now moot. It is a fundamental legal principle that adjudicative bodies should typically refrain from deciding a question where the facts have rendered the legal issues moot.[32] A claim is moot if it has lost its character as a present, live controversy.[33] This is the case if changes in circumstances that prevailed at the beginning of the case "have forestalled any occasion for meaningful relief."

Here, Ms. S.'s own witness, Dr. T., admitted that the probability of an MRA currently providing information to help him diagnose or treat Ms. S. is low. Thus, although the parties disagree whether an MRA was medically necessary at the time it was originally requested, there is no dispute that an MRA is not currently medically necessary.
Accordingly, the preauthorization request for an MRA is moot.

Regarding Dr. T.'s and Ms. S.'s suggestion that the Division should preapprove the MRA anyway, in case Ms. S.'s symptoms worsen or she has an acute incident suggestive of a stroke, the Alaska Medicaid program is not intended to preapprove procedures just in case circumstances change, as Dr. U. explained. In the event of a change in Ms. S.'s condition that she or her doctor believes necessitates an MRA, the appropriate avenue would be to submit another MRA preauthorization request at that time, being mindful of the need to timely submit all relevant medical information, including information requested

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30 7 AAC 105.130(a)(10)
31 7 AAC 105.110(1) and (2).
32 *Akpik v. State, Office of Management & Budget*, 115 P.3d 532, 535 (Alaska 2005); *Vanek v. State, Bd. of Fisheries*, 193 P.3d 283, 287 (Alaska 2008).
33 *O'Callaghan v. State*, 920 P.2d 1387, 1388 (Alaska 1996); *Ahtna Tene Nene v. State, Dept. of Fish & Game*, 288 P.3d 452, 457 (Alaska 2012).

during the Division's review process. As Ms. Baldwin explained, there is no limit on the number of times Ms. S. may make a preauthorization request.[34]

## IV. Conclusion

Ms. S.'s request for preauthorization of an MRA is moot, and the Division's decision to deny her request is affirmed. This conclusion in no way prevents her from requesting authorization of an MRA in the future.

DATED: July 23, 2024.

By: *Signed*
Lisa M. Toussaint
Administrative Law Judge

[34] Just because the Division denied Ms. S.'s request before does not mean a future request based on new information and circumstances will also be denied. Dr. U.'s testimony.

# Adoption

The undersigned, by delegation from the Commissioner of Health, 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 7th day of August, 2024.

By: *Signed*
Name: Lisa M. Toussaint
Title: Administrative Law Judge

[This document has been modified to conform to the technical requirements for publication. Names may have been changed to protect privacy.]