STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-19045 PA
Case No. [redacted]

[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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], mother, appeared as the Appellant's representative. [redacted] appeared and testified. [redacted], represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for prosthetic leg components?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] year old Medicaid beneficiary who underwent a below the knee amputation of his left leg in [redacted], due to bone cancer. (Exhibit 3, page 1)

2. The Department received the Prior Approval-Request/Authorization, signed by [redacted] on [redacted], [redacted] requesting three specialized prosthetic components for the Appellant. (Department Exhibit 1, page 5)

3. On [redacted], the Department reviewed the prior authorization request and effectively denied the request by taking "no action" because the codes for these components are not covered by Medicaid. (Department Exhibit 1, page 5)

4. On [redacted], the State Office of Administrative Hearings and Rules received the Appellant's hearing request. (Department Exhibit 1, page 3)

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.

The Medical Supplier section of the Medicaid Provider Manual addresses non-covered items stating "for specific procedure codes that are not covered, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter." (MDCH Medicaid Provider Manual, Medical Supplier Section 1.10, October 1, 2009, pages 14-16) The Coverage Conditions and Requirements section for below knee lower extremity prosthetics states:

2.37 PROSTHETICS (LOWER EXTREMITIES)

Definition
Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemi-pelvectomy prostheses.

Standards of Coverage
A **lower extremity prosthesis** may be covered to restore mobility for a beneficiary who demonstrates the ability to transfer and/or ambulate, and the beneficiary's potential functional level is between the ranges of K1 through K4.

Documentation
Documentation must be less than 60 days old and include the following:

- Diagnosis/medical condition related to the service requested.
- Current functional "K" level.
- An occupational or physical therapy evaluation may be required on a case-by-case basis when PA is required.

PA Requirements Below Knee Prosthesis

- Preparatory prosthesis - PA is not required for a BK preparatory prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5510, L5520, or L5530) and the following add-ons:
  - one test socket
  - insert
  - suspension system (e.g., L5666 or L5670)
  - total contact
  - distal cushion

The SACH foot is included with the BK preparatory base code. If any prosthetic foot other than a SACH foot is placed on a preparatory prosthesis, it will require prior authorization and must be transferred to the definitive prosthesis.

- Definitive Exoskeletal BK prosthesis – PA is not required for a BK definitive exoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5100, L5105, L5050) and the following add-ons:
  - up to two test sockets
  - socket material
  - total contact
  - distal cushion
  - foot
  - suspension locking system
  - insert
  - gel liner

- Definitive Endoskeletal BK Prosthesis - PA is not required for a BK definitive endoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5301, L5311) and the following add-ons:
  - up to two test sockets
  - socket material
  - total contact
  - distal cushion
  - foot
  - suspension locking system
  - insert
  - gel liner
  - cover

> Socks and sheaths are not considered as add-ons and would be considered in addition to the other add-on items for either the preparatory or definitive prosthesis.
>
> *MDCH Medicaid Provider Manual,*
> *Medical Supplier Section 2.37,*
> October 1, 2009, pages 64-66.

The cost of a product or service is a consideration under Medicaid policy. The program overview states that Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics. (MDCH Medicaid Provider Manual, Medical Supplier Section 1, October 1, 2009, page 1) In determining medical necessity, Medicaid policy again considers "the most cost effective treatment available." (MDCH Medicaid Provider Manual, Medical Supplier Section 1.5, October 1, 2009, pages 3-4)

In the present case, the Department determined that Medicaid policy does not allow for coverage of the specialized prosthetic components requested for the Appellant. Specifically, the Department Analyst testified that these procedure codes are not coverable as they are not included in the MDCH procedure code database. Additionally, the Department Analyst explained that these components are specialized to allow a high degree of functionality, however, they are not the most cost effective treatment available.

The Appellant and his mother disagree with the Department's denial and testified that these particular components allow the Appellant to return to the most active and functional level, including playing sports. The Appellant's mother stated that Medicare and other state's Medicaid allows coverage for these procedure codes, as would automotive insurance or workers compensation if the Appellant's amputation had been the result of a motor vehicle or work place accident.

However, this ALJ must review the action taken by the Department under the applicable Medicaid policy in this state, which does not allow coverage for these specialized prosthetic components. Section 2.37 of the Medical Supplier portion of the Medicaid Provider Manual does allow for coverage of a lower extremity prosthesis to restore mobility. However, the requested procedure codes, L5910, L5940, and L5987, for the specialized components requested for the Appellant are not included in the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database. (Exhibit 1, pages 10-12) Based on the testimony it is clear that these components are specialized to allow the highest degree of functionality for the Appellant. It is also clear that they are more expensive than other alternative components which would still restore mobility. This does not mean that the Appellant would not receive the most benefit from the requested components or that he is not deserving of them, but only that the Medicaid policy does not allow for coverage of these specialized components. Accordingly, the Department's denial must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for prosthetic leg components under the applicable Medicaid policy.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 04/27/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.