STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
______________________/

Docket No. 2010-46475 QHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. The Appellant represented herself at hearing.

[redacted], a Michigan Department of Community Health contracted Medicaid health plan, was represented by [redacted]. [redacted] was present and provided testimony.

ISSUE

Did the Plan properly deny the Appellant's request for 2 GenuMedi knee orthotics?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary. (uncontested)
2. The Appellant's physician wrote a prescription for 2 GenuMedi knee orthotics (braces) to address the Appellant's diagnosis of chondromaladia patella.
3. The aforementioned prescription was provided to [redacted] medical supply company, who submitted it to the Appellant's health plan, [redacted].
4. [redacted] reviewed the request and accompanying documentation and thereafter denied the request for Medicaid coverage of the item, stating the standards of coverage had not been met by the supporting documentation submitted.

5. The supporting documentation submitted with the request is the prescription from the Appellant's doctor indicating a diagnosis of chondromaladia patella. No other documentation was submitted.

6. The Medical Director determined the request for prior authorization lacked some of the clinical documentation necessary for the plan to make an approval.

7. [redacted] denied the request for Medicaid coverage of the knee braces on [redacted].

8. The Appellant appealed the denial on or about [redacted].

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.

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. (Bold emphasis added).

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004, Page 30.

As it says in the above Department - MHP contract language, a MHP such as may limit services to those that are medically necessary and that are consistent with applicable Medicaid Provider Manuals. It may require prior authorization for certain procedures. The process must be consistent with the Medicaid Provider Manual. The pertinent sections of the Medicaid Provider Manual criteria for prior authorization and medical necessity are below:

> **1.10 PRIOR AUTHORIZATION**
> Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:
>
> - Procedures identified as requiring PA on the procedure code databases on the MDCH website;
> - Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
> - Referrals for elective services by out-of-state nonenrolled providers.

Medicaid Provider Manual
Version Practitioner
Date: July 1, 2009 Page 4

> **1.5 MEDICAL NECESSITY**
> Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.
>
> A service is determined to be medically necessary if prescribed by a physician and it is:
>
> - Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
> - Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
> - Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
> - Inappropriate to use a nonmedical item.
> - The most cost effective treatment available.

Medicaid Provider Manual
Version Medical Supplier
Date: July 1, 2009 Page 3

The Medicaid Provider Manual has standards of coverage for lower extremity orthotics. It states:

2.26 ORTHOTICS (LOWER EXTREMITY)
Definition Lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.

Standards of Coverage
Lower extremity orthotics are covered to:

- Facilitate healing following surgery of a lower extremity.
- Support weak muscles due to neurological conditions.
- Improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy).

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

- Diagnosis/medical condition related to the service requested.
- Medical reasons for appliance requested including current functional level.
- A physical therapy evaluation may be required on a case-by-case basis when PA is required.
- Reason for replacement, such as growth or medical change.
- Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.**
- Medical justification for each additional component required.

For repairs, a new prescription is not required if the original orthotic was covered by MDCH. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.

PA Requirements PA is not required for the following if the Standards of Coverage are met:

- Fracture orthosis for fractures.
- Hip orthosis for Legg Perthes.

- Prefabricated knee appliances.
- Custom fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament.
- Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO).
- Custom fabricated plastic AFOs if up to four additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface).
- Custom fabricated metal AFOs if up to six additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition to the other items.
- Custom fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions).
- Custom fabricated metal KAFOs if up to eight additional components with the base code as indicated in the MDCH Medical Supplier Database (add-ons include: double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition the other items.

If other add-on items not listed above or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance.

For **repairs**, up to two episodes per year, as follows:

- The total repair cost equals one hour of labor or less.
- The cost of minor parts equals $50 or less.

PA is required for:

- Custom fabricated knee orthoses for all other diagnoses/medical conditions.

- Hip Knee Ankle Foot Orthosis (HKAFO) for all other diagnoses/medical conditions.
- Fracture orthosis for all other diagnoses/medical conditions.
- Other base codes or additional codes indicated as requiring PA in the MDCH Medical Supplier Database.
- Repair costs exceed the maximum limits as stated above.
- Replacement within six months for a beneficiary under the age of 21, from the original service date.
- Replacement within two years for a beneficiary over the age of 21, from the original service date.

Payment Rules
These are covered as **purchase only** items.

Version Medical Supplier
Date: October 1, 2010 Page 53

The MHP stated the denial was based upon a lack of necessary information in order to find the standards of coverage had been met. Specifically, there was no documentation that the Appellant had undergone surgery on her lower extremities, requires the braces to support weak muscles due to neurological conditions or to improve function due to a congenital paralytic syndrome (i.e. muscular dystrophy). [redacted] further testified standard knee braces are available over the counter at drug and grocery stores without need for a prescription.

The Appellant provided testimony that she does have a neurological condition and foot drop. She asserted her doctor provided documentation of these things. She did not have any documentation (such as copies) to support her assertion that her doctor had submitted the needed documentation.

The health plan refuted the Appellant's testimony by stating the only documentation submitted was included with the hearing summary and consisted only of the prescription.

After consideration of the testimony and documentation in evidence, this ALJ finds the health plan was appropriate to deny coverage for the requested knee braces based upon the documentation submitted. Certainly, if the Appellant's medical condition does meet the standards of coverage as set forth in the Medicaid Provider Manual, documentation of such does exist and could easily be provided by her physician. She is free to re-request at anytime.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find [redacted] denial of

coverage for 2 knee braces in accord with the applicable portion of the Medicaid Provider Manual.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 10/28/2010

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.