STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2011-13386 QHP
Case No. 92431904

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]. [redacted], the Appellant, appeared on her own behalf.

[redacted] was represented by [redacted]. [redacted] is a Department of Community Health contracted Medicaid Health Plan.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for knee orthosis?

FINDINGS OF FACT

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

1. In [redacted], the MHP received and denied a prior authorization request for elastic knee orthoses for the Appellant from [redacted]. (Exhibit 1, page 6 and [redacted] Testimony)

2. On [redacted], the Appellant's enrollment in [redacted] terminated. ([redacted] Testimony)

3. In [redacted], the Appellant received the requested knee orthoses from [redacted]. (Appellant Testimony, Exhibit 1, page 9)

4. On [redacted], a claim reconsideration was submitted to the MHP with additional information for the claim to be reviewed for adjustment consideration. (Exhibit 1, pages 7-9 and 11-13)

5. On [redacted], the MHP again denied the prior authorization request for knee orthoses as noncovered. (Exhibit 1, pages 15 and 17-20)

6. The Appellant requested a formal, administrative hearing contesting the denial on [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.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH 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.*

Section 2.26 of the Medical Supplier portion of the Medicaid Provider Manual, as effective October 1, 2010, addresses orthopedic footwear.

> **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 **purchase only** items.

Medicaid Provider Manual, Medical Supplier Section, October 1, 2010, Pages 52-53.

The denial notice indicates that [redacted] follows coverage guidelines using the State of Michigan fee for services coverage code listing found in the State of Michigan Medicaid fee schedule. The requested elastic knee orthoses, coded L1800, are not included in the covered codes by the State of Michigan and are therefore excluded from coverage by [redacted]. (Exhibit 1, pages 15-20)

The Appellant disagrees with the denial and testified that it had been four years since her last set of knee stabilizers. The old set is now all stretched out and needed to be replaced. (Appellant Testimony)

Medicaid policy does allow for coverage of lower extremity orthotics if the standards of coverage are met. It is noted that the specific code listed for the requested orthoses, L1800, is not included in the Michigan Department of Community Health (MDCH) Medical Supplier/DME/Prosthetics and Orthotics Database, January 1, 2010, page 111 of 157.

In the present case, it is also clear that the requested orthoses were provided to the Appellant without first obtaining prior authorization. The original prior authorization request was submitted and denied in [redacted]. ([redacted] Testimony) The requested items were provided to her on [redacted]. (Exhibit 1, page 6) The Claim reconsideration was not submitted until [redacted]. (Exhibit 1, pages 7-9 and 11-13) Further, the Appellant's enrollment in [redacted] terminated effective [redacted]. Accordingly, the Appellant was not enrolled with [redacted] when the requested knee orthoses were actually delivered to her. 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 MHP properly denied the Appellant's request for elastic knee orthoses.

[redacted]
Docket No. 2011-13386 QHP
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IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/7/2011

***** 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.