STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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]

Docket No. 2011-49274 QHP
Case No. [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]. The Appellant appeared without representation. His witness was his friend, [redacted]. [redacted], Appeals Coordinator, represented the Medicaid Health Plan (MHP). Her witness was [redacted], Chief Medical Officer.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for a Dynasplint adjustable knee brace?

FINDINGS OF FACT

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

1. The Respondent, [redacted], is a Michigan Department of Community Health (MDCH) contracted Medicaid Health Plan (MHP).

2. The Appellant is a [redacted]-year-old Medicaid beneficiary, who is enrolled in the Respondent MHP.

3. The Appellant has been diagnosed with the sequela of left knee pain, post bilateral TKA. (Exhibit A, pages 7, 14)

4. On [redacted], the MHP received a request for coverage of a Dynasplint knee extension for the Appellant. The request included a billing code of E1810. (Exhibit A, page 7-14)

5. On [redacted], the MHP sent the Appellant notice that the request for a Dynasplint knee extension device because the billing code [E1810] is not a covered benefit code. (Exhibit A, page 1)

6. On [redacted], the Department received the Appellant's Request for Hearing.

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. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor 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 2.024.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:
>
> - Ambulance and other emergency medical transportation
> - Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
> - Certified nurse midwife services

- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)

- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

(1) The major components of the Contractor's utilization management (UM) program 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 UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

....

Contract, *Supra,* p. 49.

As stated in the contract, the MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." However, the Medicaid Provider Manual (MPM) states that the "MHPs may also choose to provide services over and above those specified." *See* MPM, [MHP] October 1, 2011, page 1.

The MHP explained that it denied the Appellant's request for the flexion device [knee brace] because it was not a covered benefit code under the MDCH database. However, the Appellant's surgeon, [redacted], certified, along with supporting information, that the brace was medically necessary. [Respondent's Exhibit A, pp. 9-14]

The Appellant testified that he is in significant pain and is post knee replacement by three and a half months. He said he is having a difficult recovery even with physical therapy and desires to avoid additional surgery. The MHP witness agreed that he should be further on in recuperation and stated that they would contact the Appellant to help arrange alternative care.[1]

As for the denial of the knee brace, unless supplanted with new treatment plans, it remains a matter of medical necessity posed for resolution by the ALJ today. The Centers for Medicare and Medicaid Service (CMS) have advised that insurers cannot make coverage determinations based on procedure codes. *See* CMS Healthcare Common Procedure Coding System (HCPCS) Level II Coding Procedures. [42CFR414.40]

"The HCPCS is a system for identifying items and services. It is not a methodology… for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for making determinations regarding coverage and payment."[2]

There was no evidence from the MHP that the device was not medically necessary.

Medicaid beneficiaries are entitled to medically necessary Medicaid-covered services. 42 CFR 440.230. Absent alternative treatment plans between the parties, which are not under review today, the brace should have been approved as a medically necessary device.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan improperly denied the Appellant's request for a knee brace [Dynasplint knee extension device].

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[1] The parties were advised to contact the Michigan Administrative Hearing System if the matter resolved with the provision of alternative service. The Appellant did not withdraw his appeal and there was no contact from the MHP.

[2] *HCPCS Coding Procedures*, F. Eggleston, [Rev. July 26, 2011] §B page 2. @ www.law.cornell.edu accessed Sept. 29, 2011; *See also* MPM, Medical Supplier, §§1.2.A – 1.5.D, Oct. 1, 2011, pp. 2-7

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/9/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.