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

[redacted]

Appellant
_____/

Docket No. 2011-9040 QHP
Case No. 2215611

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], appeared as a witness for [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 an ankle-foot 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. The Appellant is [redacted] Medicaid beneficiary who is enrolled in [redacted], a Department of Community Health contracted Medicaid Health Plan (MHP).

2. The Appellant has been diagnosed with chronic ankle pain/arthropathy. (Exhibit 1, page 6)

3. On [redacted], a request for ankle-foot orthosis was submitted to the MHP by Appellant's provider. (Exhibit 1, pages 4-6)

4. On [redacted], the MHP sent a letter to the Appellant's provider stating that the request for a right ankle foot orthotic (brace) was denied because the information submitted did not show that the orthopedic footwear was needed to help with healing after an injury/surgery on the ankle/foot, to help with weakness due to a medical condition of the nerves, or because the member is not able to move or use the ankle or foot due to a disease since birth causing paralysis. (Exhibit 1, pages 7-8)

5. 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.

On [redacted] the Appellant's provider submitted a request for a right ankle-foot orthotic with lace closure and soft interface to the MHP. (Exhibit 1, page 5) Under the Medicaid Provider Manual Standards of Coverage, lower extremity orthotics are covered to facilitate healing following surgery of a lower extremity, to support weak muscles due to neurological conditions, or to improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy). The [redacted] explained that the documentation submitted with the prior authorization request did not establish that the Appellant met the standards of coverage. The only information provided was the Appellant's diagnosis of ankle arthropathy/chronic ankle pain, and that the orthotic is for the right ankle. (Exhibit 1, pages 5-6)

The Appellant disagrees with the denial and testified that this MHP paid for an ankle brace ten years ago, but that brace has worn out. She explained that despite the pins and screws, her right ankle still has broken bones and post traumatic arthritis. The Appellant stated that she can not drive, uses a 4-prong cane and a walker with a seat. She has had a recent hospitalization for pneumonia and also has additional impairments.

Based on the documentation submitted to the MHP with the prior authorization request the Appellant did not meet the Medicaid standards of coverage for a lower extremity orthotic. The medical documentation did not establish that the brace is needed to help with healing following surgery of a lower extremity, to support weak muscles due to neurological conditions, or to improve function due to a congenital paralytic syndrome. Accordingly, the Department's denial must be upheld.

The Appellant may always submit a new prior authorization request with supporting documentation of her injury, recent x-rays or other documentation of her current condition.

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 an ankle-foot orthotic based on the documentation submitted.

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: 2/22/2011

***** 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.