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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-10338 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]. [redacted], the Appellant, appeared on his own behalf. Priority Health was represented by [redacted], Director of Medicaid. Priority Health is a Department of Community Health contracted Medicaid Health Plan (MHP).

ISSUE

Did the MHP properly deny the Appellant's 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 47 year-old Medicaid beneficiary.

2. On or about [redacted], the MHP received a request for coverage for a prosthetic leg with various components for the Appellant. (Exhibit 1, pages 5-6)

3. On [redacted]12, the MHP sent the Appellant a notice that the request for two of the components, L5910 alignable system and L5645 external frame flexible inner socket, were denied because the codes are not included in the covered codes by the MDCH fee schedule. (Exhibit 1, pages 7-8)

4. On [redacted], the MHP sent the Appellant a notice that the request for additional below knee shrinker, was denied because the request exceeds the covered amount and information does not show that the

additional quantities are medically/clinically necessary. (Exhibit 1, pages 9-10)

5. [redacted], the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System.

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 also states that the "MHPs may also choose to provide services over and above those specified." *Department of Community Health, Medicaid Provider Manual, Medicaid Health Plan Section, Version Date: October 1, 2012, Page 1*.

The pertinent sections of the Michigan Medicaid Provider Manual are as follows:

> **1.5 MEDICAL NECESSITY [CHANGES MADE 7/1/12]**
>
> Medical devices 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.
>
> The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDCH standards of coverage.
>
> Medical equipment may be determined to be medically necessary when all of the following apply:
>
> - The service/device meets applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
> - It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
> - The function of the service/device:
>   - meets accepted medical standards;
>   - practices guidelines related to type, frequency, and duration of treatment; and
>   - is within scope of current medical practice.

- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order.
- The service/device meets the standards of coverage published by MDCH. **(revised 7/1/12)**
- It meets the definition of Durable Medical Equipment (DME), as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

Department of Community Health,
Medicaid Provider Manual, Medical Supplier Section
Version Date: October 1, 2012, Pages 4-5

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:

- o one test socket
- o Insert
- o suspension system (e.g., L5666 or L5670)
- o total contact
- o 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:
  - o up to two test sockets
  - o socket material
  - o total contact
  - o distal cushion
  - o foot
  - o suspension locking system
  - o insert
  - o 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:
  - o up to two test sockets
  - o socket material
  - o total contact
  - o distal cushion
  - o foot
  - o suspension locking system
  - o insert
  - o gel liner
  - o cover
  - o 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.

Department of Community Health,
Medicaid Provider Manual, Medical Supplier Section
Version Date: October 11, 2012, Pages 66-67.

The MHP explained that it denied the Appellant's request for two of the components, L5910 alignable system and L5645 external frame flexible inner socket, because the codes are not included in the covered codes by the MDCH fee schedule. Similarly, the MHP denied the prior authorization request for additional below knee shrinkers because the request exceeded the covered amount per the MDCH fee schedule. (Director of Medicaid Testimony; Exhibit 1, page 11) However, the MHP failed to establish the medical necessity of the requested components was considered. Rather, when asked to address medical necessity, the Director of Medicaid indicated that generally with excessive numbers of an item, the MHP denies the request and has a conversation with the provider to limit the amount if it exceeded the fee schedule quantity limit. Regarding the codes denied for not being included in the MDCH fee schedule, the Director of Medicaid indicated they are excluded from coverage and while the components may be medically necessary they are not a covered benefit. (Director of Medicaid Testimony)

The Appellant testified that they are medically required and described the operation, the bone spur, and skin thickness issues. If the Appellant does not have these medically necessary things, it will put him back in a wheelchair and will have to build ramps in his house. (Appellant Testimony)

The printed [redacted] fax transmission line toward the top of the prior authorization request shows "P. 9." (Exhibit 1, page 5) Accordingly, it appears that additional documentation was submitted with the prior authorization request but was not included in the hearing exhibit because only two pages of the prior authorization request were included. (Exhibit 1, pages 5-6) Therefore, it is unknown if the documentation submitted with this prior authorization request established the medical necessity of the requested prosthetic leg components and/or quantities.

This ALJ understands that two of the requested codes are not included in the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database and for the third denied code, the quantity requested is over what is listed as a limit in the database. A code being included in the database, and the listed quantity limitations, would generally indicate the item is covered and would be medically necessary when the standards of coverage are met. However, even the database itself notes at the bottom of each page that the information is for reference only, does not guarantee services are covered, and providers should refer to the Medicaid Provider Manual policy, MSA Bulletins and other relevant policy for specific coverage and reimbursement policies. (*MDCH Medical Supplier/DME/Prosthetics and Orthotics Database October 2012;* Exhibit 1, page 11) Similarly, the lack of codes or quantities being included in this database is not itself sufficient to establish that the requested components or quantities are not medically necessary for the Appellant. The MHP did not establish that the Appellant's prior authorization request was considered under the Medicaid Provider Manual policy or some other criteria to review the medical necessity of the requested components and quantities of components.

Medicaid beneficiaries are entitled to medically necessary Medicaid-covered services. 42 CFR 440.230. The MHP did not present sufficient evidence to establish that the requested components and/or quantities of components are not medically necessary for the Appellant. Accordingly, the MHP must re-process the Appellant's prior authorization request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP improperly denied the Appellant's request for prosthetic leg components.

IT IS THEREFORE ORDERED that:

> The Medicaid Health Plan's decision is REVERSED. The MHP shall re-process the Appellant's prior authorization request for the denied prosthetic leg components.

\s\
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/14/2013

***** 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.