

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:

████████████████████,

Appellant

Docket No. 2013-53177 QHP

██████████ ██████████

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 ██████████ the Appellant, appeared on her own behalf. ██████████ Appeals Coordinator, represented ██████████ the Medicaid Health Plan ("MHP"). ██████████, Medical Director, appeared as a witness for the Respondent MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for replacement prosthetic brace and socket?

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 ██████-year-old Medicaid beneficiary who is enrolled in ██████████, a Department of Community Health contracted MHP. (Exhibit 1, page 6)
2. The Appellant has been diagnosed with amputation of leg and diabetes. (Exhibit 1, page 6)
3. On or about ██████████ ██████████ received a request for replacement prosthetic brace and socket with related components for the Appellant. Included was a letter from the Appellant's doctor indicating the Appellant has lost volume in her stump, which has become a fit and comfort issue. The included progress notes, in the physical exam sections addressing the right lower extremity indicate no skin breakdown noted, no open areas or drainage, and no evidence of infection. (Exhibit 1, pages 5-16)

4. This requested prosthetic brace and socket would be the fourth in less than █ years for the Appellant. (Medial Director Testimony)
5. The Michigan Department of Community Health Medical Supplier █ quantity limits for beneficiaries over age █ is █ every █ years for a below the knee acrylic socket and for below the knee total contact. (Michigan Department of Community Health Medical Supplier Database, █ page 63 of 75)
6. On █, the MHP sent a letter to the Appellant stating that the request was denied because the requested prosthetic brace and sockets are over the quantity allowed per the Michigan Department of Community Health Medical Supplier █ and the requested items are not a covered benefit. (Exhibit 1, pages 17-20)
7. On █, the Michigan Administrative Hearing System 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/EPSTD 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 Department-MHP contract language above, a MHP, “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” The pertinent sections of the Michigan Medicaid Provider Manual (MPM) state:

1.2 MDCH MEDICAL SUPPLIER/DME/PROSTHETICS AND ORTHOTICS DATABASE

For specifics regarding the Healthcare Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, ICD diagnosis codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

1.8.C. REPAIRS AND REPLACEMENT PARTS

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDCH will consider

replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section of this chapter apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.

1.9 PROSTHETICS AND ORTHOTICS

For custom-fabricated prosthetics and orthotics (P&O), MDCH reserves the right to request a recommendation from an appropriate physician subspecialist, physical therapist (PT) or occupational therapist (OT) evaluation when necessary to determine the functional and/or medical need for the item requested.

1.9.B. HCPCS MODIFIERS - LEFT AND RIGHT SIDE OF THE BODY

The LT or RT modifier must be reported for orthoses and prostheses to designate either the left or right side of the body, if applicable. The frequency limits are based on the individual item being replaced. If the same code is used bilaterally on the same date of service, the modifiers LT and RT must be entered on the same line of the claim listing the appropriate combined quantities. To determine whether a procedure code requires the LT or RT modifier, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website. (Refer to the Directory Appendix for website information.)

1.9.C. ADJUSTMENTS, REPLACEMENTS AND REPAIRS

Adjustments related to the delivery of orthoses are considered as part of the purchase price and are not separately reimbursable up to 90 days following placement. Providers are still responsible for the replacement, modification, and adjustment of any orthotic or prosthetic item that they placed but was not fitted properly. It is

expected that the provider will adjust the device if possible before billing the program for modifications or replacements when there is unexpected growth spurt, substantial weight loss or gain, or post surgery.

2.37 PROSTHETICS (LOWER EXTREMITIES)

Definition

Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemipelvectomy 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:
 - one test socket
 - insert
 - suspension system (e.g., L5666 or L5670)
 - total contact
 - 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:
 - up to two test sockets
 - socket material
 - total contact
 - distal cushion
 - foot
 - suspension locking system
 - insert
 - 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:
 - up to two test sockets
 - socket material
 - total contact
 - distal cushion
 - foot
 - suspension locking system
 - insert
 - gel liner
 - cover
 - 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.

PA is required for either a below knee or above knee prosthesis when:

- The standards of coverage are not met.
- Any component part of the prosthesis requires PA.
- The beneficiary is over the age of 21 and replacement is required within five years.
- The beneficiary is under the age of 21 and replacement is required within two years.

Decision and Order

On or about ██████████ ██████ a received a request for replacement prosthetic brace and socket with related components for the Appellant. (Exhibit 1, pages 5-16) This requested prosthetic brace and socket would be the fourth in less than █ years for the Appellant. (Medial Director Testimony) The Michigan Department of Community Health Medical Supplier ██████████ quantity limits for beneficiaries over age █ is █ every █ years for a below the knee acrylic socket and for below the knee total contact. (Michigan Department of Community Health Medical Supplier ██████████, ██████████ page 63 of 75)

The Appellant disagrees with the denial but acknowledged that the MHP has been more than generous. However, the Appellant needs the replacement prosthetic components because her limb is continuously shrinking so the prosthetic does not fit properly at all. This has resulted in rubs against her skin, sliding, and it falling down. The rubs against her skin make sores. The Appellant loves to be mobile and does not want to be dependent on anyone else. The Appellant was concerned that she may end up having further amputation of her leg if she does not get this replacement. (Appellant Testimony)

The above cited Medicaid policy allows for quantity limits, but also allows for replacement to be considered when there has been a significant change in the medical condition that would reflect a change in equipment need. It appears the MHP has been following the Medicaid policy as multiple prior replacements have been approved in less than three years. The documentation submitted with this prior authorization request included a letter from the Appellant's doctor indicating the Appellant has lost volume in her stump, which has become a fit and comfort issue. However, the included progress notes, in the physical exam sections addressing the right lower extremity indicate no skin breakdown noted, no open areas or drainage, and no evidence of infection. (Exhibit 1, pages 5-16) The Appellant's concerns are very understandable, but it was not clear that medical necessity of the replacement was established with the submitted documentation. Accordingly, the MHP's determination to deny this prior authorization request is upheld.

If there is any additional change(s) in the Appellant's condition or further documentation that could establish medical necessity of the requested replacement prosthetic components, a new prior authorization request can be submitted to the MHP.

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 replacement prosthetic brace and socket based on the available information.

[REDACTED]
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IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

[REDACTED]
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

***** 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.