

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:

Docket No. 2013-59650 QHP

██████████
Appellant
_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████ ██████████ Appellant, appeared and testified. ██████████ Appeals Coordinator, represented ██████████, the Medicaid Health Plan (MHP). ██████████, Medical Director, testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for an Orthotic knee brace?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a ██████ year old female Medicaid beneficiary who is currently enrolled in the Respondent MHP.
2. On ██████████ the MHP received a completed Prior Authorization Request Form from Appellant's physician, requesting a right knee brace with hinges on Appellant's behalf due to Appellant having a diagnosis of osteoarthritis of the lower limb. (Exhibit A)
3. On ██████████, the MHP sent the Appellant a denial notice stating that the request for the lower extremity orthotic (knee brace) was denied as there was no documentation to establish that Appellant met the medical eligibility criteria for the brace.

(Department Exhibit A, p. 7)

4. On ██████████, the Appellant's Request for Hearing, protesting the denial, 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 (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, Page 30.

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.*

The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

2.26 ORTHOTICS (LOWER EXTREMITY)

Lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.

Lower extremity orthotics are covered to:

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- 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 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.

*Department of Community Health,
Medicaid Provider Manual, Medical Supplier Section
Version Date: April 1, 2013*

The MHP must cover services consistent with the scope of services covered by the Michigan Medicaid fee-for-service program. As stated above, the health plan may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

Appellant was denied coverage for a right knee brace. The MHP denied the request on the basis that medical documentation was not provided to establish that Appellant met the eligibility criteria. The MHP's Medical Director testified that the Medicaid Provider Manual lists the specific criteria that must be met in order to be approved for lower extremity orthotics, and Appellant did not meet any of the listed criteria.

The MHP's denial is in accordance with the applicable Medicaid policy and must be upheld. Appellant's documentary evidence on the Prior Authorization Request Form states that she needs the brace due to osteoarthritis of the lower limb. The Medicaid policy lists the conditions under which lower extremity orthotics are covered, and a diagnosis of osteoarthritis is not one of the conditions listed.

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DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for an orthotic knee brace.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/s/
Marya A. Nelson-Davis
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

MAND/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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.