

**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. 2013-60225 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. ██████████, Inquiry Dispute Appeals Resolution 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 an ankle brace?

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 Molina Healthcare, a Department of Community Health contracted MHP.
2. The Appellant has been diagnosed with ankle sprain and tenosynovitis of the ankle. (Exhibit 1, page 5)
3. On ██████████ a request for an ankle brace was submitted to the MHP by Appellant's provider. (Exhibit 1, pages 4-7)
4. On ██████████ the MHP sent a letter to the Appellant stating that the request was denied based on the Michigan Department of Community Health Medical Supplier, 2.26 Orthotics (Lower Extremity) criteria. (Exhibit 1, pages 8-11)
5. 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

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- 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:

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.

*Medicaid Provider Manual, Medical Supplier Section,
July 1, 2013, Pages 52-53.*

On ██████████, a request for an ankle brace was submitted to the MHP by Appellant's provider. The Appellant has been diagnosed with ankle sprain and tenosynovitis of the ankle. (Exhibit 1, pages 4-7) The Medical Director testified that tenosynovitis is an inflammation of the tendon. The Medical Director stated that the Appellant's tendon is inflamed and causing her pain. The Medical Director explained that the requested ankle brace could not be authorized because the documentation submitted with the prior authorization request did not establish that the Appellant met any of the three criteria in

the above cited Medicaid Provider Manual Standards of Coverage for lower extremity orthotics. (Medical Director Testimony)

The Appellant disagrees with the denial and testified she no longer has a sprain and the doctor has now diagnosed her with tendonitis. The Appellant is still seeing doctor and is getting injections of anti-inflammatory medications. The Appellant needs the requested ankle brace. The Appellant does a lot of walking and does not have a car. The Appellant is in constant pain every day. (Appellant Testimony)

The Medicaid Provider Manual Standards of Coverage only allow for coverage of a lower extremity orthotic, such as an ankle brace, when it is needed to: facilitate healing following surgery of a lower extremity; support weak muscles due to neurological conditions; or improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy). While the evidence supports the Appellant's testimony that she has inflammation, this not sufficient to meet the Medicaid Provider Manual Standards of Coverage for a lower extremity orthotic. Accordingly, the MHP's determination to deny the Appellant's prior authorization request for the ankle brace must be upheld based on the available information.

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 brace.

IT IS THEREFORE ORDERED that:

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

/s/

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.