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. 2014-17617 QHP
Case No.

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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on . Appellant appeared by conference telephone and testified. The Medicaid Health Plan (MHP), of Michigan was represented by , Appeals Coordinator. Dr. , MD, Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for orthopedic inserts?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a year-old Medicaid beneficiary.

2. On , the MHP received a Prior Authorization Request Form from Appellant's physician, Dr. , requesting lower extremity orthotics (L1940, L2275, L2330, and L2820) on behalf of Appellant due to ankle fracture, chronic pain, and swelling. 824.8; 719.47. (Exhibit A.4)

3. On the MHP denied the prior authorization request on the grounds that the Michigan DCH Medicaid Provider Manual does not allow coverage of a lower extremity orthotic absent showing a need for the orthotic in order to: 1) facilitate with healing after surgery; 2) support weak muscles due to a neurological condition, or 3) improve function due to a congenital paralytic syndrome pursuant to 2.26) Medicaid Provider Manual 2.24. (Exhibit A.6)

4. On Appellant filed a hearing request.

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 MHPs.

The Respondent is one of those MHPs. The MHP signs a contract with the State of Michigan identifying certain services that are required. The applicable Contract between the DCH and the MHP states in part:

> 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:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) 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].

In this case, there is no issue regarding the scope or language of the Contract as the MHP indicated at the administrative hearing that the Medicaid Provider Manual is applicable. Evidence of the MHP provided by the MHP addressing Appellant's request is found in 2.26 Orthotics (Lower Extremity). This section states in part:

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). (Exhibit A.2)

Michigan Department of Community Health
Medicaid Provider Manual; Practitioner
Version Date: April 1, 2013

In this case, Appellant indicated that the fracture occurred in . Appellant further stated that he did not have surgery as just after the fracture he "got locked up." Appellant further testified that it is hard to walk, and that the fracture healed in all different directions. Appellant did not dispute any of the evidence presented by the MHP.

Appellant's situation is unfortunate. However, the purview of an Administrative Law Judge (ALJ) is to review the action taken by the MHP and to make a determination if that action is correct under all applicable authority, at the time the MHP took its action. Under the above cited authority, as applied to these facts, this ALJ finds that the MHP correctly denied Appellant a lower extremity orthotic based on the information provided by Appellant's physician. Thus, the denial must be upheld.

It was noted that Appellant is certainly welcome to take the policy to his physician for review. It was further noted that if Appellant has a change in circumstance, or if Appellant's physician performs any procedures that may change the facts herein, Appellant should reapply.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for a lower extremity orthotic was correct.

IT IS THEREFORE ORDERED that:

The MHP's decision is **AFFIRMED**.

Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

Date Signed: January 31, 2014

Date Mailed: February 4, 2014

***** 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.