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. 2014-24360 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 her own behalf.

[redacted], Attorney at Law, represented [redacted] of Michigan (MHP) Dr. [redacted], Director of Utilization Management, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a K-4 an above–the-knee prosthesis artificial leg-with a knee microprocessor (C-leg)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted]-year-old SSI Medicaid beneficiary and is enrolled in an MHP.

2. On [redacted], MHP-a Department of Community Health contracted Medicaid Health Plan-received a request for prior authorization for a K-4 C-leg prosthesis [redacted] from Comfort Prosthetics & Orthotics. On or about [redacted] Appellant's physician filed a request for PA.

3. On [redacted], the MHP issued a Notification of Denied Service letter to the Appellant indicating the referral request for an "above the knee prosthesis with microprocessor" was denied because the clinical information submitted does not support medical necessity under the MHP Policy for Determination of Medical Necessity, and, because the information

submitted do not show that a prosthesis without a knee microprocessor would not allow Appellant to function at her prior community level.

4. On [redacted], the Michigan Administrative Hearing System received the Appellant's Request for Hearing.

5. Due to a subsequent internal additional level of review due to Appellant's hearing request, on [redacted] the MHP once again issued a second denial.

6. The MHP stipulated that Appellant's current prosthesis does not fit correctly and that Appellant does need a new prosthesis.(Testimony)

7. Appellant's leg was amputated in [redacted] due to diabetes. Appellant was an avid hiker, and very active in outdoor activities prior to her amputation. Appellant's BMI is normal.

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.

The Respondent is one of those MHPs.

> 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 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:

> **7.6.C LOWER EXTREMITY PROTHESES**
>
> For all lower extremity prostheses, modifiers "KO" through "K4" must be reported to designate the potential functional ability of a beneficiary (before a prosthesis is furnished)based on the reasonable expectations of the prosthetist and treating physician.
>
> **MODIFIERS AND DESCRIPTION**:
>
> KO: …does not have the ability or potential to ambulate…
>
> K1: …has the ability or potential to use a prosthesis for transfer or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory.
>
> K2: …has ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulatory.
>
> K3: …has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to transverse most environmental barrier and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
>
> K4: …has the ability or potential for prosthetic ambulation that exceeds the basic, ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
>
> MDCH Medicaid Provider Manual,
> Billing & Reimbursement for Professionals Section,
> January 1, 2014, Page 41

Also applicable to the facts herein is the concept of "medical necessity." Both the Medicaid Provider Manual as well as the MHP contract state that medical devices are covered only when "medically necessary." The Medicaid Provider Manual defines medical necessity as:

> **1.5 MEDICAL NECESSITY**
>
> 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 Requirement Section of this chapter.
>
> …Medical equipment may be determined to be medically necessary when all of the following apply:
>
> …It is the most cost effective treatment available….
>
> MDCH Medicaid Provider Manual,
> Medical Supplier Section,
> January 1, 2014, Pages 4-5.

> The MHP contract or Certificate of Coverage likewise states that any prosthetic corrective device is a benefit only if it is a "Medically Necessary device…" 2012, p 44
>
> MDCH Medicaid Provider Manual,
> Medical Supplier Section,
> January 1, 2013, Pages 30-31 and 87

The DCH-MHP contract provisions also allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the MHP's Policy and Procedure Manual, Determination of Medical Necessity.

The MHP's policy is consistent with the Medicaid standards of coverage which only allows authorizations of medical equipment items that meet the definition of "medically necessary."

In this case, the MHP denied Appellant the c-leg due to 'no clear reason given showing the medical necessity of a knee microprocessor at this time' as required by the MDCH Guidelines. (Exhibit A) Other denial reasons were given.

This ALJ has reviewed the credible and substantial evidence and finds that the medical necessity criteria, that is part the MDCH Medicaid Provider Manual, and, incorporated into the MHP's contract, allows the MHP to deny equipment provided any less costly alternative is available. On this basis alone, the MHP has the authority to deny the c-leg.

Appellant argues that the MHP makes large profits may be factually correct. However, the MHP is not stating that Appellant is not eligible for a prosthetic leg; it is saying that Appellant does not meet the medical necessity criteria for a c-leg. The criteria in the Medicaid policy and the MHP contract cited by the MHP allows for a K-4 denial. As this denial is consistent with the MHP's contract, and that contract is consistent with the Medicaid Provider Manual, this ALJ must uphold the denial.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied Appellant's September 24, 2013 prior authorization request for a C-leg.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

Date Signed: March 14, 2014

Date Mailed: March 17, 2014

[redacted]

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.