

**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. 2014-35984 QHP
Case No. ██████████

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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████, Appellant's daughter, appeared and testified on Appellant's behalf. Appellant also appeared but did not testify. Attorney ██████████ represented ██████████, the Medicaid Health Plan (MHP). Dr. ██████████, Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for an EZ Knee Extension Turnbuckle Orthosis?

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, born ██████████. (Exhibit A, p 5)
2. On or about ██████████, the MHP received a Prior Authorization Request from Joint Active Systems, Inc. on behalf of Appellant for an EZ Knee Extension Turnbuckle Orthosis. The diagnoses listed in the prior authorization request supporting the request for the orthosis was 719.46 Joint Pain-L/Leg, subsequent to Appellant's second knee replacement surgery. (Exhibit A, pp 3-22; Testimony)
3. On ██████████, the MHP advised Appellant and the supplier that the request for an EZ Knee Extension Turnbuckle Orthosis was denied because the device was considered experimental and unproven. (Exhibit A, p 23;

Testimony)

4. On ██████████, the provider requested an internal appeal on Appellant's behalf. The appeal was heard by the MHP's Member Appeal Committee on ██████████, and the original denial was upheld. (Exhibit A, pp 43-134)
5. On ██████████, Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS). (Exhibit 1)

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 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:

- (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].

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."

With regard to Lower Orthotics, the Medicaid Provider Manual states, in pertinent part:

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).

*Medicaid Provider Manual
Medical Supplier Chapter
April 1, 2014, p 52*

With regard to the specific device requested here, an EZ Knee Extension Turnbuckle Orthosis, the MHP's policy provides, in pertinent part:

MECHANICAL STRETCHING AND CONTINUOUS PASSIVE MOTION DEVICES

* * * *

Static progressive (SP) stretch splint devices and patient actuated serial stretch (PASS) devices, such as the ERMI Extensionater and Flexionater, for the treatment of joint contractures of the extremities alone or combined with standard physical therapy are unproven.

Clinical evidence is not sufficient to demonstrate that use of static progressive or patient actuated devices improves long-term patient outcomes. Evidence is limited primarily to short term outcomes and lack of comparison to other treatment modalities.

* * * *

Exhibit A, pp 24-25

The MHP's medical director testified that the requested knee orthotic was denied according to policy because it was considered experimental and unproven. The MHP's medical director also pointed to studies within the MHP's policy that support this determination. (See Exhibit A, pp 34-35). The MHP's Medical Director testified that Medicaid does cover devices or treatments that are experimental and unproven.

Appellant's daughter testified that she understood the MHP's position, having gone through the local appeal process. Appellant's daughter indicated that, in fact, the physical therapist has since tried other methods and those methods seem to be working.

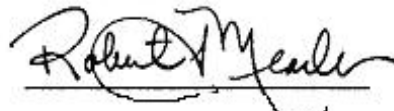
Appellant has failed to prove, by a preponderance of the evidence, that the MHP improperly denied the requested EZ Knee Extension Turnbuckle Orthosis. As indicated above, devices such as these are considered experimental and unproven and, as such, are not covered by Medicaid. Therefore, the EZ Knee Extension Turnbuckle Orthosis was properly denied.

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 Appellant's request for an EZ Knee Extension Turnbuckle Orthosis was proper.

IT IS THEREFORE ORDERED that:

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



Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [REDACTED]

RJM [REDACTED]

Date Signed: [REDACTED]

Date Mailed: [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.