STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 14-015591 MHP

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

After due notice, a hearing was held on [redacted]. The Appellant appeared on her own behalf. [redacted], Inquiry Dispute Appeals Resolution Coordinator, represented the Medicaid Health Plan (MHP), [redacted], Medical Director appeared as a witness for the MPH.

ISSUE

Did the MHP properly deny the Appellant's request for a back brace?

FINDINGS OF FACT

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

1. Appellant is a [redacted]-year-old (DOB [redacted]) Medicaid beneficiary. Receiving services under the Healthy Michigan Plan. (Exhibit A. pp 5-8).

2. On [redacted], the MHP received a Prior Authorization Request from [redacted] on behalf of the Appellant for a back brace from Wright and Filippis, more specifically described as a L0484 – TLSO Brace. (Exhibit A, pp. 5-8 and testimony).

3. On [redacted], denial letters were sent to the Appellant and the Appellant's doctors. The reason for the denial was that the L0484 – TLSO Brace was not a Medicaid covered benefit under the *Medicaid Provider Manual*, *Medical Supplier*, *§2.27 - Orthotics (Spinal)*, p. 54, October 1, 2014. (Exhibit A, pp. 3, 10-13 and testimony).

4. On [redacted], the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 2).

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:
>
> - The prevention, diagnosis, and treatment of health impairments
> - The ability to achieve age-appropriate growth and development
> - The ability to attain, maintain, or regain functional capacity
>
> 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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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, 1/23/2013, pp. 22-23].

* * *

AA. Utilization Management

(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. 55].

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 *Medicaid Provider Manual*, *Medical Supplier*, *§2.27 - Orthotics (Spinal)*, p. 54, October 1, 2014 states in part:

> **2.27 ORTHOTICS (SPINAL)**
>
> **Definition**
>
> Spinal orthotics include, but are not limited to, cervical, thoracic, lumbar, sacral, spinal, thoracic mid belt lumbar sacral, and sacroiliac orthotics.
>
> **Standards of Coverage**
>
> Spinal orthotics are covered to:
>
> - Facilitate healing following a spinal injury.
> - Arrest or correct the curvature of the spine or spondylolisthesis greater than grade 1.
> - Support weak spinal muscles due to atrophy and/or a deformed spine.
> - Facilitate healing following spinal surgery.
>
> **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.
> - Functional needs of the beneficiary.
> - Reason for replacement, such as growth or medical change.
> - Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.**

Respondent's documentary evidence established that on [redacted], the MHP received a Prior Authorization Request from [redacted] on behalf of the Appellant for a back brace from Wright and Filippis, more specifically described as a L0484 – TLSO Brace. (Exhibit A, pp. 5-8). Thereafter, on [redacted], denial letters were sent to the Appellant and the Appellant's doctors. The reason for the denial was that the L0484 – TLSO Brace was not a Medicaid covered benefit under the *Medicaid Provider Manual*, *Medical Supplier*, *§2.27 - Orthotics (Spinal)*, p. 54, October 1, 2014. (Exhibit A, pp. 3, 10-13).

[redacted] testified on behalf of the MHP and indicated that according to the policy contained in the Medicaid provider Manual the TLSO Brace requested is not a covered benefit under Michigan Medicaid unless it meets the Standards of Coverage contained in the Medicaid Provider Manual. The Standards of Coverage and the required Documentation set forth in the *Medicaid Provider Manual*, *Medical Supplier*, *§2.27 - Orthotics (Spinal)*, require submission of documentation that is less than 60 days old showing a medical condition relating to the request; medical reasons for the requested appliance; and, the functional needs of the member (documentation showing how the appliance will assist the member).

[redacted] stated the documentation submitted with the PA request showed that the Appellant's back injury was [redacted] months ago. [redacted] noted the doctor's prescription submitted with the PA request was issued on [redacted]. [redacted] stated the medical documentation indicated the injury occurred in [redacted], and the Appellant had T-12 and L-1 endplate fractures that would have healed within the [redacted] months that passed before the PA request was submitted for the back brace. Therefore, the PA request did not meet the Standards of Care as it did not show a medical reason or a functional need for the brace and did not meet the requirement for timely documentation (less than [redacted] days old). Accordingly, the request for the back brace for the Appellant had to be denied based on the above quoted policy contained in the Medicaid Provider Manual.

Appellant dropped off the call before she could present any testimony. The undersigned called both numbers for the Appellant but received no answer, and the Appellant failed to call back after dropping off the call, as she had done to initiate the hearing in the first place.

The Appellant failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her request for a back brace from Wright and Filippis, more specifically described as a L0484 – TLSO Brace. The MHP and an administrative law judge are bound by the policy contained in the Medicaid Provider Manual that was cited by the Respondent MHP and must deny the Appellant's request for Medicaid coverage for the requested back brace.

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 back brace from Wright and Filippis, more specifically described as a L0484 – TLSO Brace was proper.

IT IS THEREFORE ORDERED that:

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

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/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.