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. 14-011987 MHP

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.*, and upon a request for a hearing filed on the minor Appellant's behalf.

After due notice, a telephone hearing was held on , Appellant's mother, appeared on Appellant's behalf and testified through an interpreter. Appellant was also present during the hearing, but did not participate. , Manager of Medicaid Operations, appeared and testified on behalf of , the Respondent Medicaid Health Plan (MHP).

ISSUE

Did the MHP properly deny Appellant's request for bilateral dynamic stretching ankle-foot orthotics?

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 ten-year-old Medicaid beneficiary who is enrolled in the Respondent MHP. (Exhibit A, page 6).

2. On or about , the MHP received a prior authorization request for bilateral custom molded foot orthotics made on Appellant's behalf by . (Exhibit A, pages 5-9).

3. In the request, the medical provider noted that Appellant had been diagnosed with plantar fascial fibromatosis; equinus deformity of foot, acquired; and pes planus. (Exhibit A, page 6).

4. The medical provider also noted that the requested orthotics would reduce Appellant's pain and joint stress; allow him to be more physically active; and improve his stability. (Exhibit A, page 9).

5. The MHP subsequently approved the request for bilateral custom molded foot orthotics. (Testimony of Appellant's representative; Testimony of .

6. On or about , the MHP received a prior authorization request from made on Appellant's behalf and requesting bilateral dynamic stretching ankle-foot orthotics. (Exhibit A, pages 11-15).

7. In that request, the medical provider noted the same diagnoses as before, while also stating that the orthotics were necessary for nighttime use as Appellant's daytime orthotics do not stretch. (Exhibit A, pages 13-15).

8. The medical provider also stated in the request that the orthotics would increase passive range of motion while reducing the likelihood of further deformity and pain. (Exhibit A, pages 13-15).

9. On , the MHP sent Appellant's representative written notice that the request for nighttime ankle-foot orthotics was denied. (Respondent's Exhibit D, pages 1-2).

10. Regarding the reason for the denial, the notice stated in part that:

> Information reviewed by us shows the requested Ankle Foot Orthotics (AFO) are for night time use and not for use with daytime ambulation. Therefore, the requested AFO has been determined to be not medically/clinically necessary and has been denied.
>
> This decision is based on medical director review of information submitted by your doctor and your Certificate of Coverage (COC), Section 5, Schedule of Covered Services, B. Referral Care, 31. Prosthetic and Orthotic/Support Devices, which states; Coverage is for standard orthotic/support devices only. Prosthetic or orthotic devices that are not conventional or not Medically/Clinically Necessary as determined by us, or for the convenience of the Member or caregivers are not Covered.

Exhibit A, page 17

11. On [redacted], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed on Appellant's behalf in this matter. (Exhibit A, page 3).

12. A hearing was scheduled for [redacted], but was unable to be completed on that date because Appellant's representative needed an interpreter, but had not requested one prior to the hearing.

13. The hearing was then rescheduled for and held on [redacted].

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.

In 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 MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)
>
> <u>MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies.</u> (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.)

> Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

MPM, January 1, 2015 version
Medicaid Health Plan Chapter, page 1
(Emphasis added by ALJ)

Here, pursuant to the authority granted under both its contract with the Department and the language of the MPM, the MHP has developed utilization management criteria. (Testimony of [redacted]). With respect to prosthetic and Orthotic/Support Devices, that criteria states in part:

> You have Coverage for standard prosthetics and orthotic/support devices only. Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary as determined by us, or for the convenience of the Member or caregivers are not covered.

Exhibit A, page 20

Here, the MHP's witness testified that the prior authorized request for bilateral dynamic stretching ankle-foot orthotics was denied pursuant to the above policy. Specifically, he testified that the MHP's Medical Director reviewed the request and found that the requested orthotics were neither conventional nor medically necessary.

In response, Appellant's representative testified that she requested the orthotics at the recommendation of Appellant's doctor and that doctor believed the items to be medically necessary.

Appellant and representative bear the burden of proving by a preponderance of the evidence that the MHP erred in denying his request.

Given the limited record in this matter, the undersigned Administrative Law Judge finds that Appellant and his representative have met their burden of proving that the MHP erred.

While Appellant's representative and sole witness could not address the basis for the request, Appellant's medical provider at least attached documentation to the prior authorization request indicating why, in the view of Appellant's doctor, the requested

orthotics were necessary in addition to the recently-approved orthotics for use during the day.

The MHP, on the other hand, relied solely on its representative's hearsay testimony and broad, unsupported statements that its medical director had determined that the requested orthotics should be denied. The MHP did not submit any evidence or testimony as to why the requested orthotics were not conventional or medically necessary, and its sole witness could not identify any specific basis for the medical director's opinion.

Given the complete lack of evidence or relevant testimony submitted by the MHP, the evidence attached to Appellant's prior authorization is essentially unchallenged. Moreover, based on that evidence, the MHP erred and its decision must be reversed.

However, while the undersigned Administrative Law Judge finds that the MHP erred given the record and evidence presented during the hearing, it is not clear that Appellant ultimately meets the criteria for the requested items and the MHP will therefore only be ordered to initiate a reassessment of Appellant's request at this time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP improperly denied Appellant's request for bilateral dynamic stretching ankle-foot orthotics.

IT IS THEREFORE ORDERED that:

> The Medicaid Health Plan's decision is **REVERSED** and it must initiate a reassessment of Appellant's prior authorization request.

Steven Kibit
Administrative Law Judge
For Nick Lyon, Director
Michigan Department of Community Health

Date Signed:

Date Mailed:

SK/db

cc:

***** 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.