

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

██████████,

Appellant

CASE INFORMATION

Docket No.: 15-004885 MHP
Case No.: ██████████
Appellant: ██████████
Respondent: ██████████

HEARING INFORMATION

Hearing Date: May 21, 2015
Start Time: 11:00 AM

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 telephone hearing was held on May 21, 2015. Appellant appeared and testified. ██████████ Manager of Medicaid Operations appeared and represented/testified on behalf of ██████████ (MHP or ██████████ or Respondent).

ISSUE

Did the MHP properly deny the Appellant's request for L1932 Ankle-Foot Orthotic Rigid anterior Tibial Section?

FINDINGS OF FACT

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

1. Priority Health is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.
2. Appellant was an enrolled member of ██████████ at the time of the request for services and continues to be enrolled.

3. Appellant has diagnoses of multiple sclerosis, right foot drop, vision disturbance and chronic low back pain.
4. The ██████████ member handbook and certificate of coverage were sent at the time of enrollment.
5. The Member Handbook outlines covers limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.
6. On ██████████, ██████████ submitted a Prior Authorization form to ██████████ for an Ankle-Foot Orthotic, Rigid Anterior Tibial, provider code ██████████ (Respondent's Exhibit A page 7)
7. The request was denied based on ██████████ ██████████ ██████████ Orthotics/Support Devices. (Respondent's Exhibit A page 15)
8. On ██████████ Notice of Denial was sent to Appellant and his treating physician. (Exhibit C)
9. On ██████████, Appellant filed a request for a hearing to contest the negative action.

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 ██████████, 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/EPSTDT 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."

Respondent's representative testified that the request was denied based on the ██████████ Medical Policy No. 91339-R8 Orthotics/Support Devices. Section I. Policy/Criteria A. states "Coverage is available for standard orthotics/support devices

only. Restrictions and limitations apply.” Section III. Application to Products – Medicaid/Healthy Michigan Plan: “For Medicaid Supplies/DME/Prosthetics and orthotic support, please refer to the Medicaid Fee Schedule to verify coverage.”

The Priority Health Handbook and Certificate of coverage, Section 5 – Schedule of covered Services, B. Referral Care, point 3 states “you have coverage for standard prosthetics and orthotic/support devices only.” (Respondent’s Exhibit A pages 19-22)

The State of Michigan Medicaid Provider Manual details the conditions required for coverage and Section 2.26 Orthotics (Lower Extremity) indicates that 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.

██████████ determined that orthotics are a covered benefit and that Appellant did meet the above stated criteria. However, Provider code L1932 is not a covered item. This particular item is not included on the Michigan Department of Community Health (now Department of Health and Human Services) Medical Supplier/DME, Prosthetics and Orthotics list of covered items. The Lower Extremity Orthotic that is covered by Medicaid is L1960. (Respondent’s Exhibit A pages 1-2)

Appellant has failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied the requested medication. The denial is based upon Medicaid benefit exclusion. The Medicaid Health Plan (MHP) does not have discretion to approve Appellant’s request for items which are not covered Medicaid benefits. The decision to deny the request for authorization must be upheld under the circumstances.

[REDACTED]
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Decision and Order

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's approval of the Appellant's request for L1339-R8 Orthotic/Support Device was proper under the circumstances.

IT IS THEREFORE ORDERED that:

The MHP's is **AFFIRMED**.

Landis Y. Lain

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department Health and Human Services

LYL/ [REDACTED]

cc: [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.