



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[REDACTED]

Date Mailed: [REDACTED]
MAHS Docket No.: 16-002446
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

DECISION AND ORDER

After due notice, a hearing was held on [REDACTED]. Petitioner was represented by [REDACTED], Paralegal, and [REDACTED] MD, Medical Director for the Health Plan appeared as witness on behalf of the Michigan Department of Health and Human Services' subcontractor, [REDACTED] (Respondent or MHP).

ISSUE

Did the MHP properly deny the Petitioner's request for knee braces?

FINDINGS OF FACT

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

1. Petitioner is a [REDACTED] year-old male beneficiary of the Medicaid welfare program.
2. On [REDACTED], the MHP received a Prior Authorization Request on behalf of Petitioner for "LT and RT Armor Ci Knee Brace Left and Right" along with a RT and LT knee control condylar pad and a RT and LT soft interface molded plastic (Exhibit A.11).
2. On [REDACTED] the MHP issued a denial letter of Petitioner's request for "a knee brace" on the grounds that Petitioner did not meet the criteria in the Medicaid Provider Manual (MPM), requiring a recent surgery, nerve or neurologic muscle disorder, and that there is no proof that the brace will help or protect the knee. (Exhibit A.5).

3. On [REDACTED], the Petitioner filed a Request for Hearing.

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/EPSTDT 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:

2.26 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). MPM, 2.26.

Section 2.26: Orthotics (Lower Extremity)

The MPM also lists the PA Requirements found on Exhibit A.8 in the Respondent's evidentiary packet.

Respondent's documented evidence established that on [REDACTED], the MHP received a Prior Authorization Request on behalf of Petitioner for "LT and RT Armor Ci Knee Brace Left and Right" along with a RT and LT knee control condylar pad and a RT and LT soft interface molded plastic (Exhibit A.11).

Evidence further shows that on [REDACTED] the MHP issued a denial letter of Petitioner's request for the reason that Petitioner did not meet the criteria in the Medicaid Provider Manual (MPM), 2.26. Specifically, evidence shows that Petitioner's evidence did not show that he meets any of the standards of coverage required by the MPM under Section 2.26-orthotics (lower extremity). In addition, under the PA Requirements of the MPM, the PA evidence did not meet the requirements as laid out in Exhibit A.8.

After a careful review of the credible and substantial evidence of record, this ALJ finds that the MHP properly denied the PA in this case. Specifically, the criteria established in the MPM Sections 2.26 cited above are not met based on the facts in this case. The medical records here do not show that Petitioner meets the requirement set in the MPM for approval.

The Petitioner failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied his request for knee braces. The MHP and the undersigned 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 Petitioner's request for Medicaid coverage for the requested orthotics based on the available evidence of record.

At the administrative hearing, Petitioner expressed understanding that he may reapply if he has other documentation that would show eligibility, which may have happened by the time of the Decision and Order. However, based on the evidence as of the [REDACTED] denial date, this denial was supported by credible and substantial evidence of records, and thus, must be upheld.

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 Petitioner's request for knee braces was correct based on the available evidence.

IT IS THEREFORE ORDERED that:

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

JS/cg



Janice Spodarek

Administrative Law Judge

for Nick Lyon, Director

Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[REDACTED]

Petitioner

[REDACTED]

Authorized Hearing Rep.

[REDACTED]

Community Health Rep

[REDACTED]