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: November 23, 2016
MAHS Docket No.: 16-013504
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Petitioner's request for a hearing.

After due notice, a hearing was held on October 26, 2016. [redacted], mother, appeared on behalf of the Petitioner. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted] Departmental Analyst, appeared as a witness for the Department.

During the hearing proceeding, the Department's Hearing Summary packet was admitted as Exhibit A, pp. 1-18.

ISSUE

Did the Department properly deny Petitioner's request for prior authorization for carbon granite lamination for a custom Ankle Foot Orthosis (AFO)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a 3 year old Medicaid beneficiary, date of birth [redacted]. (Exhibit A, p. 9)

2. On August 25, 2016, the Department received a prior authorization request for a custom AFO with carbon granite lamination. On the detailed written order, there was no justification listed for the code relating to the high-strength, lightweight material, L2755. (Exhibit A, pp. 9-11)

3. On September 12, 2016, the Department sent letters to Petitioner and the requesting provider indicating the carbon graphite lamination was denied based the policy regarding specific procedure codes that are not covered. (Exhibit A, pp. 5-8)

4. On September 27, 2016, a request for hearing was filed on Petitioner's behalf. (Exhibit A, p. 4)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

Regarding prior authorization, the Practitioner section of the MDHHS Medicaid Provider Manual states:

> **1.9 PRIOR AUTHORIZATION**
>
> Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services.
>
> *MDHHS Medicaid Provider Manual, Practitioner Section, (July 1, 2016), p. 4.*

Regarding prior authorization, the Medical Supplier section of the MDHHS Medicaid Provider Manual states:

> **1.7 PRIOR AUTHORIZATION**
>
> Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-fabricated DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
> PA will be required in the following situations:
> - Services that exceed quantity/frequency limits or established fee screens.
> - Medical need for an item beyond the MDHHS Standards of Coverage.

- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required as noted in the Medicaid Code and Rate Reference tool.

MDHHS Medicaid Provider Manual,
Medical Supplier Section,
(July 1, 2016), p. 8.
(Underline added by ALJ)

Regarding non-covered items, the MDHHS Medicaid Provider Manual, in part, states:

> For specific procedure codes that are not covered, refer to the Coverage Conditions and Requirements Section of this chapter or the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information.

MDHHS Medicaid Provider Manual,
Medical Supplier Section,
(July 1, 2016), p. 20.

The Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter states:

> **1.4.A. ADDITIONAL CODE/COVERAGE RESOURCE MATERIALS**
>
> MDHHS maintains procedure/revenue code fee information in a series of website databases and professional fee schedules. These list procedure codes, descriptions, and fee screens. This information is updated as changes in coverage and/or fees are implemented. Databases and fee schedules are only available on the MDHHS website. (Refer to the Directory Appendix for website information.)
>
> Additional pertinent coverage parameters, such as documentation and billing indicators, are accessible via the Medicaid Code and Rate Reference tool. Medicaid Code and Rate Reference is an online code inquiry system that provides real-time information for the following:
>
> - Age restrictions;
> - Documentation requirements;
> - Prior authorizations, and medical conditions that may bypass these requirements;
> - Service frequency limitations; and

- Rate information.

(Refer to the Directory Appendix for website information.)

MDHHS Medicaid Provider Manual,
General Information for Provider Section,
(July 1, 2016), p. 2.

The relevant Coverage Conditions and Requirements subsection of the Medical Supplier Chapter states:

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).

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 requested including current functional level.
- A physical therapy evaluation may be required on a case-by-case basis when PA is required.
- Reason for replacement, such as growth or medical change.
- Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.**
- Medical justification for each additional component required.

For repairs, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.

PA Requirements
PA is not required for the following if the Standards of Coverage are met:
- Fracture orthosis for fractures.
- Hip orthosis for Legg Perthes.
- Prefabricated knee appliances.

- Custom-fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament.
- Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO).
- Custom-fabricated plastic AFOs if up to four additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface).
- Custom-fabricated metal AFOs if up to six additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition to the other items.
- Custom-fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions).
- Custom-fabricated metal KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition the other items.

If other add-on items not listed above or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance.

For **repairs**, up to two episodes per year, as follows:

- The total repair cost equals one hour of labor or less.
- The cost of minor parts equals $50 or less.

PA is required for:

- Custom fabricated knee orthoses for all other diagnoses/medical conditions.
- Hip Knee Ankle Foot Orthosis (HKAFO) for all other diagnoses/medical conditions.
- Fracture orthosis for all other diagnoses/medical conditions.
- Other base codes or additional codes indicated as requiring PA in the Medicaid Code and Rate Reference tool.
- Repair costs exceed the maximum limits as stated above.

- Replacement within six months for a beneficiary under the age of 21, from the original service date.
- Replacement within two years for a beneficiary over the age of 21, from the original service date.

Payment Rules These are covered as **purchase only** items.

MDHHS Medicaid Provider Manual,
Medical Supplier Section,
(July 1, 2016), pp. 59-61
(underline added by ALJ)

The Department explained that an AFO was approved for Petitioner, only the carbon fiber lamination was denied. (Exhibit A, p. 9; Departmental Analyst Testimony) The Department noted that the code for the requested carbon granite lamination, L2755, is not listed on the MDHHS Medical Suppliers/Orthotists/Prosthetisits/DME Dealers Fee Schedule (Fee Schedule). Therefore, the Department asserts that this is not covered. The Departmental Analyst indicated that because this code is not listed, the Department did not review medical necessity. (Exhibit A, p. 14; Departmental Analyst Testimony)

In part, the non-covered items policy found in the MDHHS Medicaid Provider Manual, Medical Supplier Section, does refer medical suppliers to the Department website where the Fee Schedule is accessible. However, it is noted that at the bottom of the Fee Schedule print out, it states:

> The information on this page serves as a reference only. It does not guarantee that services are covered. Providers are instructed to refer to the Michigan Medicaid provider Manual, MSA Bulletins and other relevant policy for specific coverage and reimbursement policies. This information can be found on the Medicaid Policy & Forms web page. If there are discrepancies between the information on this page and the Provider Manual, such as rate or coverage determinations, they will be resolved in favor of the Provider Manual language.
>
> (Exhibit A, p. 14)

Accordingly, the Fee Schedule itself indicates it cannot be relied upon as a definitive source for making coverage determinations. Further, the MDHHS Medicaid Provider Manual policy does not consistently support the position that if a code is not listed in the Fee Schedule, the Department can deny the request without considering medical necessity. For example, the language within the Coverage Conditions and Requirements subsection of the Medical Supplier Chapter for lower extremity orthotics appears to indicate that medical necessity would be considered for components/items not listed within the Standards of Coverage that do not require prior authorization. This is consistent with the above cited prior authorization language from the MDHHS Medicaid Provider Manual, Medical Supplier Section, stating that prior authorization is required for medical need for an item beyond the MDHHS Standards of Coverage.

Even though the Department did not consider medical necessity before issuing the denial of this component from Petitioner's August 25, 2016, prior authorization request, that determination must still be upheld based on the information submitted with this request. Specifically, the above cited Coverage Conditions and Requirements subsection of the Medical Supplier Chapter for lower extremity orthotics set forth prior authorization requirements that include "medical justification for each additional component required." The three pages submitted for the prior authorization request did not include a justification for this component. (Exhibit A, pp. 9-11) Specifically, on the detailed written order, the justification section for the code relating to the high-strength, lightweight material, L2755, was blank. (Exhibit A, p. 10) Therefore, medical necessity could not be established for this component and the determination to deny the carbon granite lamination, is upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's request for prior authorization for carbon granite lamination for a custom a custom AFO based on the information provided with the August 25, 2016, request.

IT IS, THEREFORE, ORDERED that:

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

Colleen Lack

CL/cg

Colleen Lack
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 Department Rep. [redacted]

Petitioner [redacted]

DHHS -Dept Contact [redacted]

Authorized Hearing Rep. [redacted]

Agency Representative [redacted]