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: March 24, 2017
MAHS Docket No.: 17-000493
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

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 the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on March 7, 2017. Petitioner appeared and testified on her own behalf. [redacted], Lead Coordinator for Grievance and Appeals, appeared and testified on behalf of [redacted], the Respondent [redacted] Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for a knee brace?

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 forty-nine-year-old Medicaid beneficiary enrolled in the Respondent MHP. (Exhibit A, page 5; Testimony of Respondent's representative).

2. On December 30, 2016, Respondent received a prior authorization request submitted on Petitioner's behalf for a hinged knee brace for her right knee. (Exhibit A, pages 5-6).

3. The prior authorization form identified Petitioner as having a diagnosis of right knee osteoarthritis. (Exhibit A, page 6).

4. On January 12, 2017, Respondent sent written notice that the prior authorization request were denied. (Exhibit A, pages 8-9).

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

> Information reviewed by us does not show you meet the criteria below for a lower extremity orthotic. Therefore, we are unable to approve this request.
>
> This decision is based on medical director review of information submitted by your doctor and the Michigan Department of Health and Human Services (MDHHS) Medical Provider Manual, Medical Supplier, Section 2.26 Orthotics (Lower Extremity) which states: Lower extremity orthotics are covered to:
>
> 1. Facilitate healing following surgery of a lower extremity.
>
> 2. Support weak muscles due to neurological conditions.
>
> 3. Improve function due to congenital paralytic syndrome (i.e., Muscular Dystrophy)

Exhibit A, page 8

6. On January 23, 2017, the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Petitioner with respect to that denial. (Exhibit A, page 3).

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.

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 Medicaid Health Plans.

The Respondent is one of those MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing services pursuant to its contract with the Department:

> The Michigan Department of Health and Human Services (MDHHS) 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 MDHHS website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (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, October 1, 2016 version*
> *Medicaid Health Plans Chapter, page 1*
> *(Emphasis added by ALJ)*

As stated above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations" and, as testified to by Respondent's representative, Respondent's prior authorization requirements and utilization management and review criteria likewise limit coverage of orthotics to what is covered in the Medicaid Provider Manual (MPM).

With regard to Lower Orthotics like the one request in this case, the Medicaid Provider Manual (MPM) states in the pertinent part that:

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.

Pursuant to the above policies, Respondent denied the prior authorization request in this case. In particular, as testified to by Respondent's representative and provided in its notice of denial, the request was denied because Petitioner's diagnosis of right knee osteoarthritis did not meet the applicable standards of coverage, which limits coverage of lower extremity orthotics to facilitating healing following surgery of a lower extremity; supporting weak muscles due to neurological conditions, or improving function due to a congenital paralytic syndrome.

In response, Petitioner testified that she has been having knee issues for some time and that her doctor prescribed her a knee brace because she is too young for knee replacement. Petitioner also testified that she was told by the medical supplier that it was approved when it provided her with the knee brace and that the brace has been helping her.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her prior authorization request. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

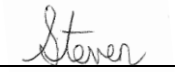
Given the available evidence and applicable policies in this case, Petitioner has failed to meet that burden of proof and the MHP's decision must be affirmed. The above policies clearly limit coverage of lower extremity orthotics to certain circumstances and none of those circumstances apply in this case. Moreover, while Petitioner has already been provided with the requested knee brace and was told that it was approved by her medical supplier, that testimony is unsupported and irrelevant to Respondent's decision, which both parties agree was a denial. Whatever dispute may remain between Petitioner and her medical supplier is beyond the scope of this proceeding and the undersigned Administrative Law Judge only finds that, with respect to the decision at issue in this case, Petitioner has failed to meet her burden of proof and the denial of her prior authorization request must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's prior authorization request.

IT IS, THEREFORE, ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.



SK/tm

Steven Kibit
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]

[redacted]

[redacted]