STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellent
_____/

Docket No. 2009-17666 QHP
Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. [redacted], represented the Medicaid Health Plan (MHP). His witness was [redacted]

ISSUE

Did the Medicaid Health Plan (MHP) properly deny Appellant's request for Podiatry services?

FINDINGS OF FACT

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

1. At the time of hearing, the Appellant is a [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant has been a member of the Respondent MHP since 2006. (Appellant's Exhibit #1)

3. The Appellant suffers from DM, bunion and soft corn deformity. (Respondent's Exhibit A, p. 10)

4. The Appellant sought approval for a right foot Austin Bunionectomy on [redacted]. (Respondent's Exhibit A, p. 1)

5. Following review the request was denied owing to information received by the MHP that the Appellant had received relief with conservative treatment – padding and medication. (Respondent's Exhibits A, pp. 1 and 10)

6. The Appellant and her provider were advised of the denial and her further appeal rights on [redacted]. (Respondent's Exhibit A, p. 1-3)

7. The instant appeal for the MHP denial of podiatric service was received by SOAHR on [redacted]. (Appellant's Exhibit 1)

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 Medicaid Health Plans.

> The Respondent is one of those Medicaid Health Plans.
>
> 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. Contractors 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 I-Z.
>
> 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 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 EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning Services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- 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)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract 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 for individuals under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)

- Vision services
- Well child/EPSDT for persons under 21.

Article II-G. Scope of Comprehensive Benefit Package, contract, 2008, p. 32.

Furthermore, the Medicaid Provider Manual (MPM) sets forth specific service requirements for MHPs to follow:

SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal Infant Health Program (MIHP)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons)

- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21 (Emphasis supplied)

MPM, §1.1 (Medicaid Health Plans) April 1, 2009, pages 1 – 2[1].

***

The MHP witness, [redacted], testified that the request for bunion surgery was denied for lack of a required x-ray demonstrating digit angulation and because the Appellant was reported to have experienced relief with conservative treatment. See Respondent Exhibit A – throughout. Finally, at hearing the Appellant raised some doubt about which foot required treatment.

On review, absent information supporting medical necessity and satisfaction of supporting criteria the MHP decision was appropriate when made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied podiatric services.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/24/2009

[1] This version of the MPM is substantially similar to the edition in place at the time of appeal.

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.