STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-6455 QHP
Case No. [redacted]
Load 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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on her own behalf.

Representing [redacted], (hereafter, 'Medicaid Health Plan' or 'MHP') were [redacted], and [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for foot inserts?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a prior authorization referral from the Appellant's primary care physician, requesting orthotic durable medical equipment. On [redacted], the MHP's Health Care Service

Department completed its review of the request, which was denied.

3. On [redacted] the MHP issued Appellant a notice of denial; the denial is based on the information supplied by the Appellant's primary care physician, which includes a diagnosis of ankle anthesopathy. The MHP contends that custom molded foot inserts as described by code (L3020) is not covered for the diagnosis of ankle anthesopathy. *(Exhibit 1; p. 1)*

4. An [redacted] letter from [redacted] to the Appellant's primary care physician describes the condition of the Appellant's foot as "…basically a corn on the bottom of her third metatarsophalangeal joint of her right foot." [redacted] letter does not address whether the foot condition derives from weak muscles due to neurological conditions, or whether the inserts improve function due to a congenital paralytic syndrome (i.e., muscular dystrophy). *(Exhibit 1; p. 4)*

5. On [redacted] the Appellant filed her Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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 (List omitted by Administrative Law Judge). 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 coverage(s) 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 1-Z.

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.

The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.

The Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, September 30, 2004.

Coverage of Orthotics, specifically, lower extremity Orthotics, are described below:

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).

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The evidence submitted directs a conclusion the Appellant does not meet criteria for coverage of foot inserts. The Appellant bears the burden of establishing she suffers from a condition under which the foot inserts would be covered. The evidence presented indicates she has failed to do so.

MHP witnesses testified the request for orthotics was denied, because the medical evidence submitted fails to address whether the Appellant's development of corn(s) has a neurological component. MHP witnesses note that, although the Appellant's primary care physician diagnosis ankle enthesopathy, the Appellant's specialist (podiatrist) does not adopt that diagnosis in his [redacted] letter, and, in fact, does not mention it. The Appellant produced no further medical evidence to address this concern.

Based on a preponderance of the evidence presented, I conclude the Appellant has failed to establish she meets criteria for foot inserts. Specifically, the record is devoid of evidence that the requested inserts will facilitate healing following surgery of a lower extremity, that the inserts will support weak muscles due to neurological conditions, or that the inserts will improve function due to a congenital paralytic syndrome. These are the conditions specifically articulated in the Medicaid Provider Manual under which coverage of lower extremity orthotic equipment would be approved.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the MHP appropriately denied the Appellant's request for orthotic foot inserts, as in accord with current policy and its contract with the Department.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/24/2009

***** NOTICE *****

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