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. 2010-43956 QHP
[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] The Appellant was represented by his mother, [redacted].

[redacted] was represented by [redacted], Medicaid Director. [redacted] is a Department of Community Health contracted Medicaid Health Plan.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for shoe insert orthotics?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant has been enrolled in [redacted] since [redacted] (Exhibit 1, page 1)

3. The Appellant has been diagnosed with pes planus (flat foot). (Exhibit 1, pages 9, 11-13)

4. On [redacted], a request for pre-molded arch support orthotics was submitted to the MHP by Appellant's provider. (Exhibit 1, pages 9-11)

5. On [redacted], the MHP sent a letter to the Appellant stating that the providers request for foot inserts was denied because shoe insert orthotics are not covered for Appellant's diagnosis. (Exhibit 1, pages 7-8)

6. The Appellant's mother requested a formal, administrative hearing contesting the denial on [redacted] (Exhibit 1, page 5)

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 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 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.*

Section 2.24 of the Medical Supplier portion of the Medicaid Provider Manual, as effective April 1, 2010, addresses orthopedic footwear. Under "Noncovered Items" shoes and inserts are listed as noncovered for the condition of pes planus or talipes planus (flat foot). *Medicaid Provider Manual, Medical Supplier Section, April 1, 2010, Pages 47-48.*

On [redacted], the Appellant's provider submitted a request for pre-molded orthotics to the MHP along with documentation of the Appellant's diagnosis, pes planus. (Exhibit 1, pages 9-11) A Medical Director for the MHP reviewed and denied the request because shoe insert orthotics are not a covered benefit for that diagnosis. (Medicaid Director Testimony and Exhibit 1, page 6)

After the MHP explained why the request was denied, the Appellant's mother testified that everything was clear.

The MHP followed Medicaid policy to establish standards of coverage for orthotic inserts, which are not covered for the Appellant's diagnosis of flat feet.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for shoe insert orthotics.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/27/2010

***** 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.