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. 2010-55804 QHP
Case No. 39817653

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 [redacted].

[redacted] was represented by [redacted]. [redacted], appeared as a witness for [redacted]. [redacted] is a [redacted] 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 [redacted] who is enrolled in [redacted], a [redacted] contracted Medicaid Health Plan (MHP).

2. The Appellant's diagnoses have been listed as congenital varus deformities and pronation, or, as bilateral internal tibial torsion and pronation. (Exhibit 1, pages 5-6)

3. On [redacted], a request for custom arch support, heel and wedge orthotics was submitted to the MHP by Appellant's provider. (Exhibit 1, pages 4-6)

4. On [redacted], the MHP sent a letter to the Appellant's provider stating that the request for orthopedic footwear was denied because the information submitted did not show that the orthopedic footwear was needed due to one leg shorter than the other, a partial artificial foot, inflamed heel, or a foot or lower leg brace. (Exhibit 1, pages 9-10)

5. The Appellant's [redacted] requested a formal, administrative hearing contesting the denial on [redacted].

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 July 1, 2010, addresses orthopedic footwear.

> **2.24 ORTHOPEDIC FOOTWEAR**
>
> **Definition**
> Orthopedic footwear may include, but are not limited to, orthopedic shoes, surgical boots, removable inserts, Thomas heels, and lifts.
>
> **Standards of Coverage**
> **Orthopedic shoes and inserts** may be covered if any of the following applies:
> - Required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater.

- Required to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fascitis.
- Required to accommodate a brace (extra depth only are covered).

Surgical Boots or Shoes may be covered to facilitate healing following foot surgery, trauma or a fracture.

Noncovered Items
Shoes and inserts are noncovered for the conditions of:
- Pes Planus or Talipes Planus (flat foot)
- Adductus metatarsus
- Calcaneus Valgus
- Hallux Valgus

Standard shoes are also noncovered.

Documentation
Documentation must be less than 60 days old and include the following:
- Diagnosis/medical condition related to the service requested.
- Medical reasons for specific shoe type and/or modification.
- Functional need of the beneficiary.
- Reason for replacement, such as growth or medical change.

CSHCS requires a prescription from an appropriate pediatric subspecialist.

PA Requirements
PA is not required for the following items if the Standards of Coverage are met:
- Surgical boots or shoes.
- Shoe modifications, such as lifts, heel wedges, or metatarsal bar wedges up to established quantity limits.
- Orthopedic shoe to accommodate a brace.
- Orthopedic shoes and inserts when the following medical conditions are present:
    - Plantar Fascial Fibromatosis
    - Unequal Leg Length (Acquired)
    - Talipes Ezuinovarus (Clubfoot)
    - Longitudinal Deficiency of Lower Limb, Not Elsewhere Classified

- Unilateral, without Mention of Complication (Partial Foot Amputation)
- Unilateral, Complicated (Partial Foot Amputation)
- Bilateral, without Mention of Complication (Partial Foot Amputation)
- Bilateral, Complicated (Partial Foot Amputation)

PA is required for:

- All other medical conditions related to the need for orthopedic shoes and inserts not listed above.
- All orthopedic shoes and inserts if established quantity limits are exceeded.
- Medical need beyond the Standards of Care.
- Beneficiaries under the age of 21, replacement within six months.
- Beneficiaries over the age of 21, replacement within one year.

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

Medicaid Provider Manual, Medical Supplier Section, July 1, 2010, Pages 49-50.

On [redacted], the Appellant's provider submitted a request for custom shoe insert orthotics to the MHP. (Exhibit 1, pages 4-6) The Medical Director explained the diagnoses listed on the Appellant's prescriptions in laymans terms, describing bilateral pronation as toeing in and internal tibial torsion as legs are slightly bowed because of the rotation of the hip. (Exhibit 1, page 6 and Medical Director Testimony) The Medical Director stated that the requested orthotics were not covered for the Appellant's diagnosis. The documentation submitted did not establish that the shoe orthotics were required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater, to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fasciitis, or to accommodate a brace. The Medical Director also explained that three of the diagnoses listed in the section for which shoes and inserts are not covered, specifically adductus metatarsus, calcaneus valgus, and hallux valgus, also relate to portions of the foot turning in.

The Appellant's [redacted] disagrees with the denial and questioned why shoes were approved in [redacted] that would not have met the standards of coverage the MHP applied. The MHP explained that for the certain items, usually based on a dollar limitation, can go through without prior authorization requiring a clinical review. It is possible the medical supplier improperly authorized the shoes and no clinical review was performed. (Medical Director Testimony) The Appellant's [redacted] also noted that the Appellant has seen a total of three pediatric foot doctors and two have indicated the orthotics are required. [redacted] stated the other said no and either the Appellant will grow out of it or may need surgery later. The Appellant's [redacted] questioned why the doctors do not agree on what treatment is necessary.

The Appellant's [redacted] raised valid issues and concerns. However, this ALJ must review the action taken by the Department under the applicable Medicaid policy. Based on the evidence, the Appellant did not meet the Medicaid standards of coverage for shoe insert orthotics. The medical documentation did not establish that the shoe orthotics were required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater, to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fasciitis, or to accommodate a brace. Accordingly, the Department's denial must be upheld.

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: 12/16/2010

***** 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.