STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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. 2011-42037 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 [redacted]. The Appellant represented herself.

[redacted] was represented by [redacted], Appeals Coordinator. [redacted] Medical Director, appeared as a witness for [redacted]. [redacted] is a Department of Community Health contracted Medicaid Health Plan.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for orthotic shoes?

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] year old Medicaid beneficiary who is enrolled in [redacted], a Department of Community Health contracted Medicaid Health Plan (MHP).

2. The Appellant wears a leg brace and requires an orthotic shoe to accommodate this leg brace. (testimony of Appellant at hearing)

3. On [redacted], a request for replacement orthotic shoes was made by [redacted] on behalf of the Appellant.

4. On [redacted], the MHP sent a letter to the Appellant and her provider stating that the request for orthopedic footwear was denied because it is not a covered benefit under [redacted] Evidence of Coverage

Guidelines. It stated further: "Per the Michigan Department of Community Health Medical Supplier, Orthotics and DME Database and the OPPS Wrap Around Codes Database, the requested billing code L3216 is not a covered benefit code for the diagnosis (medical condition) provided: 735.4 other hammer toe."

5. The Appellant 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.
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> *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.
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> *Article II-P, Utilization Management, Contract, September 30, 2004.*

The MHP failed to provide evidence it has developed coverage guidelines different from those in the Medicaid Provider Manual, therefore reference is made to the known policy. Section 2.24 of the Medical Supplier portion of the Medicaid Provider Manual, as effective July 1, 2010, addresses orthopedic footwear. There is Medicaid policy effective as of October 1, 2011, however, at the time of this decision, this policy was in effect. Furthermore, the pertinent portion of policy for the purpose of this hearing is unmodified in the latest version.

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**). (emphasis added by ALJ)

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.** (emphasis added by ALJ)
- 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.** (emphasis added by ALJ)

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

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

In this case the Appellant credibly testified she needs the orthotic shoes to accommodate a leg brace she wears. She testified she has a drop foot and drags one as she walks. She said this causes an abnormal amount of wear and tear of her shoes. She further stated she cannot afford to replace them herself due to limited disability based income. She said her current shoes have holes in them.

The MHP asserted the diagnosis presented does not allow for coverage of the item sought. Furthermore, written reference was made to lack of coverage for the specific billing code used by the Medical Supplier. This ALJ will point out, once again, that a billing code does not affect a coverage determination. There is a specific section of the Medicaid Provider Manual that spells this out. The Medicaid Provider Manual specifically addresses the issue in section 1.2.A., below.

> **1.2.A. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES**
> The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement, as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by HCPCS level I or Current Procedural Terminology (CPT) codes.
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> HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service. Decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment.
>
> National permanent codes are maintained by the Centers for Medicare & Medicaid Services (CMS) HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. The permanent national codes serve the function of providing a standardized coding system that is managed jointly by private and public insurers.
>
> National codes also include miscellaneous/not otherwise classified (NOC) codes. These codes are used when a medical supplier submits a bill or request for an item or service where there is no existing national code that adequately describes the item or service. Before using a miscellaneous/NOC code, the medical supplier should check with the Medicare Pricing, Data Analysis and Coding (PDAC) contractor to determine whether there is a specific code that should be used. (Refer to the Directory Appendix for contact and website information.)

> When submitting a bill or request, medical suppliers are required to use HCPCS codes to identify items. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. MDCH reserves the right to determine and apply correct HCPCS codes used for the purpose of reimbursement.
>
> Version Medical Supplier
> Date: October 1, 2011 Page 2
> Michigan Department of Community Health

In this case the policy in the Medicaid Provider Manual clearly states orthotic shoes are a covered benefit for those needing them to accommodate a leg brace. It is not known what the [redacted] are that are referenced in the denial notice because they were not put into the evidentiary record. Additionally, more medical evidence was submitted to the MHP by the medical supplier. (Exhibit A, page 10) There is no evidence the additional medical evidence was actually considered when the determination to deny coverage was made. Exhibit A, page 7 evidences there was a telephone call between staff at the MHP and the medical supplier specifically about this Appellant and her medical condition(s). It indicates she has a dx of dropped foot, she drags her foot which puts a lot of wear and tear on the shoes. The email goes on to indicate the dropped foot code (736.79) is not NCB per MDCH Medical Supplier/DMF prosthetics and Orthotics Database. The response from the MHP doctor is the diagnosis is hammertoe and not covered per the MDCH database. This response does not demonstrate consideration was given to the new, additional evidence the Appellant's specific medical condition includes drop foot. There is no evidence the MHP considered the Appellant's leg brace or how her gait affects the shoes already provided. The [redacted] Guidelines were not provided at hearing, so it is not established the MHP has a set of guidelines that differ from those published in the Medicaid Provider Manual. The denial of coverage merely references the MDCH billing code for a diagnosis of hammer toe. This is direct evidence the doctor at the MHP made a coverage determination based upon the MDCH billing code database, which is improper.

There is no authority cited in the record allowing a coverage determination to be based upon a billing code.

The evidence of record clearly shows the MHP improperly relied on the MDCH billing code database to make a coverage determination. The Notice itself states "the requested billing code L3216 is not a covered benefit code for the diagnosis (medical condition) provided: 735.4 hammer toe." This Notice and evidence of record fails to establish with reasonable certainly that the MHP considered any guidelines based upon medical necessity when it made its coverage determination. There is inadequate evidence of record to establish anything other than hammer toe and a billing code were considered in this case. The MHP is still required under its contract and pertinent policy, to consider whether the item sought is medically necessary for this Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP improperly denied the Appellant's request for orthotic shoes based upon use of a billing code and failed to consider whether the item sought was medically necessary.

IT IS THEREFORE ORDERED that:

> The Medicaid Health Plan's decision is REVERSED. The MHP is hereby ordered to re-consider the request using appropriate coverage criteria that address the medical necessity of the item sought.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/13/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.