

**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:

██████████

Docket No. 2012-30232 QHP

██████████

██████████

Appellant

\_\_\_\_\_ /

**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 ██████████. The Appellant was represented by her mother, ██████████.

Priority Health was represented by ██████████, ██████████. Priority Health 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 ██████-year-old Medicaid beneficiary.
2. The Appellant has been enrolled in Priority Health since ██████████. (Exhibit A, page 1)
3. The Appellant has been diagnosed with Achilles Tendonitis. (Exhibit A).
4. Priority Healthcare received a request for pre-molded arch support orthotics from the Appellant's provider.

5. On ██████████ 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.
6. The Appellant's mother requested a formal, administrative hearing contesting the denial on ██████████.

### **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 MHPs.

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. The Contractor 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 2.024.

*Section 1.022(E)(1), Covered Services.  
MDCH contract (Contract) with the Medicaid Health Plans,  
October 1, 2009.*

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

- (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- (e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

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

*Section 1.022(AA)(1) and (2),  
Utilization Management, Contract,  
October 1, 2009.*

Section 2.24 of the Medical Supplier portion of the Medicaid Provider Manual, as effective October 1, 2011, 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  $\frac{1}{4}$  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 fasciitis.
- 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 Equinovarus (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,  
October 1, 2011, Pages 49-50.*

The Appellant's provider submitted a request for pre-molded orthotics to the MHP along with documentation of the Appellant's diagnosis. 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 A)

The Appellant's mother stated this has been an ongoing problem for ██████████ and the requested inserts cost less than surgery. She stated her daughter had trauma to her foot, not surgery. She also stated when her daughter works her ankles swells up.

This ALJ considered the evidence of record. No evidence was submitted that could support the Appellant's request for coverage of the orthotic shoe inserts. This is not a finding that the Appellant would not benefit from them, only that coverage is not included as a Medicaid benefit under current coverage guidelines. The MHP followed Medicaid policy to establish standards of coverage for orthotic inserts, which are not covered for the Appellant's diagnosis.

### **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.

  
Docket No. 2012-30232 QHP  
Decision & Order

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is **AFFIRMED**.

---

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

cc:



Date Mailed: 4-20-12

**\*\*\* 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.