

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) 373-4147

IN THE MATTER OF:

██████████,
Appellant

Docket No. 2013-47447 QHP
██████████

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 ██████████ the Appellant, appeared on her own behalf. ██████████, was represented by ██████████, Staff Attorney. ██████████ is a Department of Community Health contracted Medicaid Health Plan (MHP). ██████████ Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for diabetic shoes and a wheelchair cushion?

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 and is enrolled in an MHP.
2. On or about ██████████, the MHP received a request for prior authorization for another pair of diabetic shoes, specifically the upgrade to diabetic boots, as well as a wheelchair gel cushion for the Appellant from ██████████. (Exhibit 1, pages 7-11)
3. On ██████████, the MHP issued a letter to the Appellant indicating the referral request for diabetic shoes with inserts and a wheelchair cushion was denied because the clinical information submitted does not support medical necessity under the ██████████ Medical Policy for Determination of Medical Necessity. The notes showed the Appellant has fibromyalgia and foot pain. The information did not show the

Appellant has diabetes or uses a wheelchair, which are conditions required for the items requested. (Exhibit 1, pages 12-16)

4. From ██████████ through ██████████ the MHP received additional information. (Exhibit 1, pages 17-101)
5. On ██████████, the Michigan Administrative Hearing System received the Appellant's Request for Hearing.

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.

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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services

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- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)

- Vision services
- Well child/EPSTD for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

- (1) The major components of the Contractor's utilization management (UM) program 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 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.

....

Contract, *Supra*, p. 49

As stated in the Department-██████████ contract language above, a ██████████, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) state:

2.11 DIABETIC SHOES AND INSERTS

Definition

Diabetic shoes, inserts and related modifications include, but are not limited to, depth inlay shoes, multi-density inserts, roller or rocker bottoms, wedges, metatarsal bar, and offset heel.

Standards of Coverage

Diabetic shoes, inserts, and/or modifications may be covered for individuals who have, due to complications with diabetes mellitus, one of the following conditions:

- History of previous foot ulcerations or pre-ulcerative calluses.
- Established peripheral neuropathy or sensory impairment.
- Peripheral Vascular Disease with an ankle brachial index at rest of 0.5 or less following exercise.
- Loss of a toe or portion of the foot due to amputation arising from diabetes.

A **custom-molded diabetic shoe** is covered only if the depth shoe cannot accommodate a foot anomaly.

Inserts are covered if the beneficiary requires a depth shoe or custom-molded diabetic shoe. For a depth shoe, three inserts would be separately reimbursable in addition to the noncustomized one included with the shoe. For a custom-molded shoe, two inserts would be separately reimbursable. Modifications to a custom-molded or depth shoe may be covered rather than an additional insert.

Documentation

Documentation must be less than 30 days old and include all of the following:

- Diagnosis/medical condition related to the service requested.
- Medical reasons for specific shoe type and/or modification.

PA Requirements

PA is not required for the following inserts if the Standards of Coverage are met:

- Multiple density insert, direct formed, molded to foot with external heat source.

- Multiple density insert, direct formed, compression molded to patient's foot without external heat source.
- Multiple density insert, custom fabricated and custom-molded from model of patient's foot.
- Depth inlay shoes.
- Modifications if an additional insert is not provided.

PA is required for:

- Medical need beyond the Standards of Coverage.
- Replacement within one year.
- Quantity beyond established limits.
- Custom-fabricated shoes and other inserts not included above.

Wheelchair Accessories

Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific wheelchair accessory codes when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or an addition to an existing wheelchair if:

- It is required to provide safety.
- It is required for appropriate positioning.
- It is the most economical alternative.

For additions to an existing wheelchair, the physician or the occupational or physical therapist must address the status/condition of the current wheelchair and include the brand, model, serial number, and age of the current wheelchair. If MDCH did not purchase the wheelchair being modified, all documentation requirements must be provided as if the request is for a new or initial wheelchair. Refer to the Non-Covered Items section of this chapter for information on accessories that are not covered.

MDCH Medicaid Provider Manual,
Medical Supplier Section,
January 1, 2013, Pages 30-31 and 87

See also MDCH Medicaid Provider Manual, Medical Supplier Section, January 1, 2013, Sections 1.5 Medical Necessity and 1.10 Noncovered Items, Pages 4-5 and 17-19.

The DCH-██████████ contract provisions also allow prior approval procedures for utilization management purposes. The ██████████ reviewed this prior approval request under the

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██████████ Policy and Procedure Manual, Determination of Medical Necessity. (Exhibit 1, pages 102-106)

The ██████████ policy is consistent with the Medicaid standards of coverage to only authorize medically necessary items and services, do not effectively avoid providing medically necessary services and are allowable under the DCH-██████████ contract provisions.

On or about ██████████, the ██████████ received a request for prior authorization for another pair of diabetic shoes, specifically the upgrade to diabetic boots, as well as a wheelchair gel cushion for the Appellant from ██████████ (Exhibit 1, pages 7-11)

On ██████████, the ██████████ issued a letter to the Appellant indicating the referral request for diabetic shoes with inserts and a wheelchair cushion was denied because the clinical information submitted does not support medical necessity under the ██████████ Medical Policy for Determination of Medical Necessity. The notes showed the Appellant has fibromyalgia and foot pain. The information did not show the Appellant has diabetes or uses a wheelchair, which are conditions required for the times requested. (Exhibit 1, pages 12-16)

The ██████████ Medical Director testified that the Appellant did receive shoes and a wheelchair cushion in ██████████ through an automated process. The subsequent request in ██████████ was over quantity, which triggered the prior authorization process. The Medical Director stated that the ██████████ does not deny that the Appellant has problems with peripheral vascular disease. However, the requested therapeutic shoes are specifically for diabetes and there was no documentation the Appellant has diabetes. Rather, on the Statement of Certifying Physician for Therapeutic Shoes, the Appellant's doctor crossed out diabetes mellitus and wrote in peripheral neuropathy. (Exhibit 1, page 80) Regarding the wheelchair cushion, the medical necessity of a wheelchair for the Appellant has not been established, therefore, the cushion cannot be approved. (Medical Director Testimony)

The Appellant disagrees with the denial and testified she was told she would be eligible for shoes as of ██████████ and that they can be approved once per year. The Appellant also understood the upgrade to the boot would be considered. The Appellant stated the shoes she got last year are no good. The Appellant indicated her feet may soon be amputated. The Appellant explained that the impairment began from burns from treatment of blood clots. The Appellant also explained why she needs the special shoes to walk. The Appellant further stated there were problems with the payment for the shoes last year not being timely. The Appellant stated that she or her family can no longer use that pharmacy. The Appellant testified she has made multiple prior authorization requests, pointing out the ██████████ and ██████████ prescriptions. The Appellant also stated she has a wheelchair, realizes she will not be eligible for a new cushion until next year, and will be making a request. (Appellant Testimony; Exhibit 1, pages 11 and 82)

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The documentation submitted for the [REDACTED] prior authorization request was insufficient to establish the medical necessity of the requested diabetic shoes and wheelchair cushion. It appears the Appellant previously received these items under an automated process and not because medical necessity was established for these items. The information submitted does not document that the Appellant has diabetes to establish the medical necessity of the requested diabetic shoes and inserts. (Exhibit 1, pages 7-11 and 17-101) The Medical Directory testified that the documentation is also not sufficient to establish the medial necessity of a wheelchair for the Appellant; therefore, the cushion cannot be approved. (Medical Director Testimony) Additionally, it is noted that the Appellant and the requesting pharmacy acknowledged that the Appellant was not yet eligible for a new wheelchair cushion when the [REDACTED] prior authorization request was submitted. (Exhibit 1, pages 7-11; Appellant Testimony) Accordingly, the [REDACTED] determinations must be upheld based on the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the [REDACTED] properly denied the Appellant's [REDACTED] prior authorization request for diabetic shoes and a wheelchair cushion.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____/s/_____
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

***** 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.