

**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.** 2014-15160 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.*, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on ██████████ Appellant's mother, appeared and testified on Appellant's behalf. Appellant also testified on his own behalf. ██████████, Director of Customer Services, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████ Referral Supervisor/Registered Nurse, and ██████████, Denial and Appeals Supervisor, also testified as witnesses for Respondent.

**ISSUE**

Did the MHP properly deny Appellant's request for an orthotic foot insert?

**FINDINGS OF FACT**

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

1. Appellant is a ██████ year-old male enrolled in the Respondent MHP. (Respondent's Exhibit A, page 5; Testimony of Appellant's representative).
2. On ██████████, the MHP received a prior authorization request submitted on behalf of Appellant by his doctor and ██████████ a provider of home medical equipment, prosthetics, orthotics, respiratory services, and medical supplies. (Respondent's Exhibit A, pages 4-5).
3. That request provided that Appellant had been diagnosed with talipes cavus, diagnosis code 754.71. (Respondent's Exhibit A, pages 4-5).
4. The request also identified a Healthcare Common Procedure Coding System (HCPCS) number for the requested item: L3020 (Foot, insert,

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removable, molded to patient model, longitudinal/ metatarsal support, each). (Respondent's Exhibit A, pages 4-5).

5. In reviewing that request and applying the HCPCS number to the Michigan Department of Community Health's Medical Supplier/ [REDACTED], the MHP determined that talipes cavus is not a qualifying diagnosis for the requested item and that the request must be denied. (Respondent's Exhibit A, page 6; Testimony of [REDACTED])
6. On [REDACTED], the MHP sent both Appellant and [REDACTED] written notice that the request for an orthotic foot insert was being denied as the equipment is dispensed only for qualifying diagnoses and a diagnosis of talipes cavus is not a qualifying diagnosis according to the Department's Health Fee Screen. (Respondent's Exhibit A, pages 7-8).
7. On [REDACTED], the MHP received a second request for the orthotic foot insert. (Respondent's Exhibit A, pages 12-14).
8. In that second request, Appellant was identified as having a diagnosis code of 754.69, other valgus deformities of feet. (Respondent's Exhibit A, pages 12-14).
9. Applying that diagnosis code and the HCPCS number of the requested item, the MHP again determined that Appellant did not have a qualifying diagnosis. (Respondent's Exhibit A, pages 9-11; Testimony of [REDACTED]).
10. A MHP staff member also discussed the lack of a qualifying diagnosis with a representative of [REDACTED] and requested for more information, but that representative merely asked to go forward with the prior authorization request as submitted. (Respondent's Exhibit A, pages 9-11; Testimony of [REDACTED]).
11. On [REDACTED], the MHP sent both Appellant and [REDACTED] written notice that the request for an orthotic foot insert was being denied as the equipment is dispensed only for qualifying diagnoses and a diagnosis of congenital valgus foot deformity is not a qualifying diagnosis according to the Department's Health Fee Screen. (Respondent's Exhibit A, pages 7-8).
12. On [REDACTED], the MHP received a [REDACTED] request for the orthotic foot insert. (Respondent's Exhibit A, pages 21-24).

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13. In that third request, Appellant was identified as having diagnosis codes of 844.9, sprains and strains of unspecified site of knee and leg, and 736.72, equinus deformity of foot, acquired. (Respondent's Exhibit A, pages 21-24).
14. Applying those diagnosis codes and the HCPCS number of the requested item, the MHP again determined that Appellant did not have a qualifying diagnosis. (Respondent's Exhibit A, pages 18-20; Testimony of [REDACTED]).
15. On [REDACTED], the MHP sent both Appellant and [REDACTED] written notice that the request for an orthotic foot insert was being denied as the documentation submitted did not meet the diagnosis approval criteria for the requested equipment. (Respondent's Exhibit A, pages 26-27).
16. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, page 1).

**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.

In 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 and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with

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which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

*Medicaid Provider Manual, October 1, 2013 version  
Medicaid Health Plan Chapter, page 1  
(Emphasis added by ALJ)*

As stated above, a MHP “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” Here, the pertinent sections of the applicable version of the Michigan Medicaid Provider Manual (MPM) state

## **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.

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- 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:

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- 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.

*MPM, October 1, 2013 version  
Medical Supplier Chapter, pages 50-51*

Moreover, with respect to the MDCH database and HCPCS codes utilized by the MHP in this case, the MPM states:

### **1.2 MDCH MEDICAL SUPPLIER/DME/PROSTHETICS AND ORTHOTICS DATABASE**

For specifics regarding the Healthcare Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, ICD diagnosis codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

#### **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.

\* \* \*

### **1.5 MEDICAL NECESSITY**

Medical devices are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDCH standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

- The service/device meets applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- The function of the service/device:
  - meets accepted medical standards;
  - practices guidelines related to type, frequency, and duration of treatment; and
  - is within scope of current medical practice.

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- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order.
- The service/device meets the standards of coverage published by MDCH.
- It meets the definition of Durable Medical Equipment (DME), as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

**1.5.A. PRESCRIPTION REQUIREMENTS**

A prescription must contain all of the following:

- Beneficiary's name;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number or Social Security Number (SSN) (if known);
- Prescribing physician's name, address, and telephone number;
- Prescribing physician's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;

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- The specific item prescribed;
- The amount and length of time that the service is needed; and
- State date of order if different from the physician's signature date.

The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes, but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or healthcare practitioner's signed documentation.

*MPM, October 1, 2013 version  
Medical Supplier Chapter, pages 2-6*

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Here, Respondent's representative and witnesses testified that Appellant's prior authorization requests were all denied pursuant to the above policies. Specifically, they noted that they reviewed the requests and checked the Department's database for the HCPCS number of the requested equipment and the diagnosis codes that cover such equipment. None of the requests contained diagnoses listed on the database.

In response, Appellant and his representative testified that, due to Appellant's medical problems, the requested orthotics are clearly medically necessary. They also testified that Appellant's family doctor previously prescribed a course of therapy, but that therapy was unsuccessful and Appellant was referred to a specialist, who then recommended the requested orthotics. Appellant and his representative also noted that Appellant has been diagnosed with several other conditions that are not reflected on the prior authorization requests.

Appellant and his representative bear the burden of proving by a preponderance of the evidence that the MHP erred in denying his prior authorization requests. Moreover, this Administrative Law Judge's jurisdiction is limited to reviewing the MHP's decision in light of the information it had at the time it made that decision.

As a preliminary matter, this Administrative Law Judge would note that his jurisdiction is also limited to reviewing the second two denials in this case. The Social Security Act and the federal regulations which implement the Social Security Act require an opportunity for fair hearing to any recipient who believes the Department may have taken an action erroneously. See 42 CFR 431.200 *et seq.* However, the opportunity for fair hearing is limited by a requirement that the request be made within 90 days of the negative action:

Request for hearing.

\* \* \*

(d) The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

*42 CFR 431.221(d)*

Therefore, this Administrative Law Judge only has jurisdiction to hear cases brought timely. Here, it is undisputed that the first denial notice pertaining to the issue contested by Appellant was sent ██████████ while the hearing request submitted on Appellant's behalf was received by MAHS on ██████████. Appellant's request for hearing therefore exceeded the ██████ day time period to request a fair hearing regarding that first denial and this Administrative Law Judge lacks jurisdiction over any such challenge.

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With respect to the denials that were timely appealed, this Administrative Law Judge finds that Appellant and his representative have failed to meet their burden of proving that the MHP erred. While the HCPCS is not a system for making coverage or payment determinations, the case codes and listed diagnoses were all the information the MHP had in this case and none of the diagnoses identified on the prior authorization requests are among the listed diagnoses for the requested equipment. Moreover, there was simply no evidence or information submitted along with the prior authorization requests regarding the medical necessity of the requested equipment, despite discussions with a representative of the requesting medical supplier. That lack of evidence is particularly problematic in this case given the shifting diagnoses identified by Appellant's doctor and the medical supplier.

Similarly, there was no evidence or information submitted along with the requests that would even suggest that any of the factors identified in the MPM are present. As indicated above, foot orthotics are covered if 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 fasciitis, or required to accommodate a brace (extra depth only are covered).

Accordingly, given what was submitted along with the requests and the lack of evidence regarding medical necessity, Appellant and his representative have failed to meet their burden of proof and the MHP's decision must be sustained.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's requests for an orthotic foot insert.

**IT IS THEREFORE ORDERED** that:

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



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Steven Kibit  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

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SK/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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.