



criteria in the Medicaid Provider Manual (MPM), 2.24 Orthopedic Footwear criteria. *Medicaid Provider Manual, Medical Supplier, §2.24.* (Exhibit A, p 8 and testimony).

4. On ██████████, the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 2).

### **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 MHPs.

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.

If new services are added to the ██████████ 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
- 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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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, 1/23/2013, pp. 22-23].

\* \* \*

#### AA. Utilization Management

(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. [Contract, *supra*, p. 55].

As stated in the Department-MHP contract language above, a MHP “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” The *Medicaid Provider Manual, Medical Supplier, §2.27 - Orthotics (Spinal)*, p. 54, October 1, 2014 states in part:

## **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 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.

**Non-covered 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 non-covered.

Respondent’s documentary evidence established that on ██████████ the MHP received a Prior Authorization Request from ██████████ on behalf of the Appellant for orthotics based on a diagnosis of flat foot and a bunion. (Exhibit A, p 7).

Thereafter, on ██████████, a denial letter was sent to the Appellant and the

Appellant's doctors. The reason for the denial was that Appellant does meet the MPM criteria.

Specifically, as cited above, this criteria requires evidence indicating that appellant has a leg length discrepancy of ¼ inch or greater, a size discrepancy between both feet of one size or greater, a partial foot, clubfoot or plantar fasciitis, recent foot surgery, trauma or a fracture. Moreover, the MPM specifically excludes diagnoses of hallux valgus-bunion, and flat foot. No medical evidence was submitted herein that meets the criteria identified in the MPM>

Appellant argues that her doctor said that the orthotics 'should have been covered.' Appellant offered no evidence that would override the express language of the MPM. The MHP must follow the dictates of the state with regards to covered services for the Medicaid program. Unfortunately for Appellant, a physician's opinion about what the MPM 'should' say is irrelevant.

The Appellant failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her request for orthotics. The MHP and the undersigned administrative law judge are bound by the policy contained in the Medicaid Provider Manual that was cited by the Respondent MHP and must deny the Appellant's request for Medicaid coverage for the requested orthotics based on the available evidence of record.

### **DECISION AND ORDER**

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for Foot Insert Molds/orthotics was proper based on the available evidence.

**IT IS THEREFORE ORDERED** that:

The MHP's decision is **AFFIRMED**.



\_\_\_\_\_  
Janice Spodarek  
Administrative Law Judge  
for Nick Lyon, Director  
Michigan Department of Health and Human  
Services

Date Signed: ██████████

Date Mailed: ██████████

JS/cg

[REDACTED]  
Docket No. 15-017803 MHP  
Decision and Order

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.