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:

[redacted] Docket No. 15-009946 MHP

Appellant

[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.*, following Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted] Grievances and Appeals Specialist, represented [redacted], the Medicaid Health Plan (MHP).

ISSUE

Did the MHP properly deny Appellant's request for orthopedic foot wear?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted]-year-old Medicaid beneficiary, born [redacted] enrolled with the MHP. (Exhibit A, pp 1, 6; Testimony)

2. On or about [redacted], the MHP received a Prior Authorization Request from [redacted] on behalf of Appellant for orthopedic foot wear. The diagnosis listed in the prior authorization request supporting the request for orthopedic foot wear was [redacted] flat feet. (Exhibit A, pp 6-10; Testimony)

3. On [redacted], the MHP advised Appellant and the supplier that the request for orthopedic foot wear was denied because the information supplied did not show that Appellant has a leg length discrepancy, a foot size discrepancy, a partial foot prosthesis, clubfoot, plantar fasciitis, or used a brace, as required under [redacted] Medical Policy No. 91420-R12. The MPM also provides specifically that orthotics for Pes Planus or Talipes Planus (flat feet) are not covered. (Exhibit A, pp 12-18; 28-30; Testimony)

4. On [redacted], a Request for Hearing was filed with the Michigan Administrative Hearing System (MAHS) on Appellant's behalf. (Exhibit A, p 3)

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. 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
> - 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/EPSDT 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:

(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. 49].

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 Chapter, §2.24 Orthopedic Footwear, July 1, 2015, pp 54-55 states:

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).

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.

The MHP's witness testified that the requested orthotics were not a covered item under either their medical policy or *the Medicaid Provider Manual.* The witness stated the information submitted showed that Appellant has a condition of flat feet, however, the information does not show that Appellant has a leg length discrepancy, a foot size discrepancy, a partial foot prosthesis, clubfoot, plantar fasciitis, or used a brace, as required under Section 2.24 of the MPM. The witness also pointed out that the MPM specifically indicates that orthotics for Pes Planus or Talipes Planus (flat feet) are not covered. The witness concluded that the denial of the prior authorization request in this case should be upheld.

Appellant's mother testified that Appellant needs these orthotics because she suffers from celiac disease and has a high risk of bone deformities in the future.

Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested foot orthotics. 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). None of these factors are present for Appellant. Furthermore, the MPM provides specifically that orthotics for Pes Planus or Talipes Planus (flat feet) are not covered. The documentation submitted shows that Appellant has flat feet. As such the decision made by the MHP here was based on the documentation submitted and, based on that information, the denial was proper.

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 orthotics was proper.

IT IS THEREFORE ORDERED that:

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

Corey A. Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed: [redacted]
Date Mailed: [redacted]

[redacted]
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CAA/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.