RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

Date Mailed: March 23, 2016
MAHS Docket No.: 15-019724
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

AMENDED 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 the Appellant's request for a hearing.

After due notice, a telephone hearing was held on . Petitioner appeared and testified. , Assistant General Counsel (P) represented Respondent, of Michigan (Respondent or MHP or). , Medical Director, appeared and testified on behalf of the Respondent.

Respondent's Exhibit A pages 1-52 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's request for a second pair of diabetic shoes?

FINDINGS OF FACT

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

1. Respondent is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.

2. Petitioner was an enrolled member of the MHP at all times relevant to this hearing.

3. The MHP member handbook and certificate of coverage were sent at the time of enrollment.

4. The Member Handbook outlines covers limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.

5. On [redacted], respondent received a request for diabetic shoes.

6. On [redacted], the Respondent sent Petitioner notice that the request was denied per the [redacted] Policy for Determination or Medical Necessity I.06.

7. On [redacted], Respondent received a request for a hearing, which was reviewed and upheld.

8. On [redacted], Respondent received a level 2 appeal from Petitioner.

9. On [redacted] the request for appeal was reviewed with the member and all parties of the appeal committee.

10. On [redacted], Respondent sent Petitioner notice of the affirmation of denial.

11. On [redacted], Petitioner filed a request for a hearing to contest the negative action.

12. The record was left open until [redacted], to allow for the submission of evidence by the Petitioner.

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].

Section 2.11 DIABETIC SHOES AND INSERTS of the Medicaid Provider Manual, Medical Supplier, page 36, January 1, 2016 states in pertinent part:

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 non-customized 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.
- 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.

Payment Rules All items are considered **purchase only**.

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."

MHP Policy Number I.06 states that requests for medically necessary services must, at a minimum contain:

1. Recipient diagnosis, whether a pre-existing or presenting condition, and the effect on the recipient without the treatment;
2. The medical need for the service(s) or equipment being prescribed;
3. The expected outcome and timetable of the prescribed treatment;
4. Any historical data, if applicable, of treatment plans which may or may not have been successful to treat the current condition;
5. A listing of any individuals or agencies to whom the recipient is being referred; and
6. Assurance that the prescribed service (s) or equipment is the least restrictive, most cost effective service available to meet the recipient's needs.

In the instant case, MHP records indicate that Petitioner received a pair of Diabetic shoes in [redacted]. Per MHP Policy I.06 Determination of Medical Necessity, the MHP covers only one (1) pair of diabetic shoes and (3) three pairs of inserts per calendar year. Further, the MHP notes that there were no notes showing that Petitioner's current pair of diabetic shoes are worn or are in need of replacement. Petitioner will be eligible to receive another pair of diabetic shoes on [redacted].

Petitioner testified on the record that she needs new shoes so that she can work out because her current diabetic shoes are not for working out. Petitioner provided new information: a letter dated [redacted] from [redacted] which indicated that she has several diagnosis that would benefit from daily exercise, including hypertriglyceridemia, morbid obesity, diabetes, and hypertension. She specifically requires the use of specialized diabetic shoes as a result of her diagnosis of diabetic neuropathy. She does have a pair of diabetic shoes for routine daily wear, but those shoes were not intended for regular exercise and should not be used for such activity. (Petitioner's Exhibit 1)

The MHP did not have the [redacted] letter to consider when making this decision. This Administrative Law judge is bound by the evidence that was provided to the MHP at the time the decision was made.

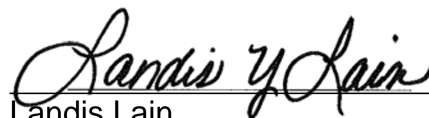
In the instant case, Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested second pair of diabetic shoes. The Medicaid Health Plan (MHP), does not have discretion to approve Appellant's request for items when insufficient evidence in support of medical necessity has been provided. Appellant's physician may resubmit a Prior Authorization request for a second pair of diabetic shoes with the appropriate documentation and the MHP will be able to consider the request. The Medicaid Health Plan (MHP) appropriately denied Appellant's request for a second pair of diabetic shoes under the circumstances. The decision to deny the request for authorization must be upheld under the circumstances.

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 a second pair of diabetic shoes was proper under the circumstances.

IT IS THEREFORE ORDERED that:

The MHP's is **AFFIRMED**.



LL/[redacted]

Landis Lain
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Petitioner

DHHS -Dept Contact

Community Health Rep