RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

Date Mailed:
MAHS Docket No.: 16-001555
Agency No.:
Petitioner:

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

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 Petitioner's request for a hearing.

After due notice, a hearing was held on . Petitioner appeared and testified. , Team Leader for Grievance and Appeals appeared on behalf of the Michigan Department of Health and Human Services subcontractor, (Respondent or MHP).

ISSUE

Did the MHP properly deny the Petitioner's request for foot insert molds/orthopedic footwear and a foot brace?

FINDINGS OF FACT

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

1. Petitioner is a -year-old female beneficiary of the Medicaid welfare program.
2. On , the MHP received a Prior Authorization Request on behalf of Petitioner for bilateral Custom Molded Shoe Inserts, and an Arizona style AFO foot brace. (Attachment B). The PA based the request on a diagnosis of flat foot and other acquired deformities of foot, bilateral. (Attachment B).

3. On [redacted] the MHP issued a denial letter of Petitioner's request for "Shoe Inserts and Lower Extremity Orthotic" for the reason that Petitioner did not meet the criteria in the Medicaid Provider Manual (MPM), 2.24 Orthopedic Footwear criteria. *Medicaid Provider Manual*, *Medical Supplier*, *§2.24 and Sec 2.26.* (Attachment C; Testimony). Level I and Level II Reviews were conducted and affirmed the decision of the MHP. (Attachments G & H).

4. On [redacted], the Petitioner filed a 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.

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 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 (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/EPSDT 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. MPM Section 2.24.

Section 2.26: Orthotics (Lower Extremity)

Definition: lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.

Standards of Coverage: Lower extremity orthotics are covered to:

- Facilitate healing following surgery of a lower extremity.
- Support weak muscles due to neurological conditions.
- Improve function due to a congenital paralytic syndrome (i.e. Muscular Dystrophy). MPM, 2.26.

Respondent's documented evidence established that on [redacted], the MHP received a Prior Authorization Request on behalf of Petitioner for bilateral Custom Molded Shoe Inserts, and an Arizona style AFO foot brace. (Attachment B). The PA based the request on a diagnosis of flat foot and other acquired deformities of foot, bilateral. (Attachment B).

Evidence further shows that on [redacted] the MHP issued a denial letter of Petitioner's request for "Shoe Inserts and Lower Extremity Orthotic" for the reason that Petitioner did not meet the criteria in the Medicaid Provider Manual (MPM), 2.24 Orthopedic Footwear criteria. *Medicaid Provider Manual*, *Medical Supplier*, *§2.24 and Sec 2.26.* (Attachment C; Testimony). Level I and Level II Reviews were conducted and affirmed the decision of the MHP. (Attachments G & H).

After a careful review of the credible and substantial evidence of record, this ALJ finds that the MHP properly denied the PA in this case. Specifically, the criteria established in the MPM Sections 2.24 and 2.26 cited above are not met based on the facts in this case. The medical records here do not show that Petitioner is experiencing complications of systemic conditions (that is, Petitioner does not have leg length discrepancy, partial foot prosthesis or plantar fasciitis which would warrant an exception to allow coverage for shoe inserts. In additions, Petitioner has not have surgery on her foot or ankle, does not have weak muscles due to a neurological condition, nor does she have a congenital paralytic syndrome that would allow coverage for an ankle/foot orthosis.

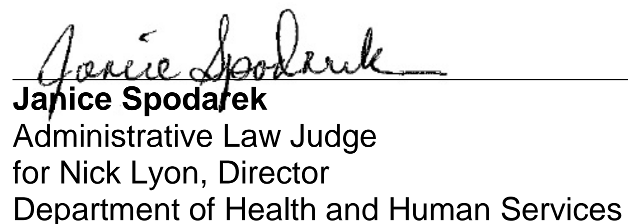
The Petitioner failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her request for orthotics. The MHP and the undersigned administrative law judge are bound by the policy contained in the Medicaid Provider Manual that was cited by the Respondent MHP and must deny the Petitioner'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 Petitioner's request for insert molds/orthopedic footwear and a foot brace was correct based on the available evidence.

IT IS THEREFORE ORDERED that:

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



JS/cg

Janice Spodarek
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

DHHS -Dept Contact

Petitioner

Authorized Hearing Rep.

Community Health Rep