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Date Mailed: August 20, 2021
MOAHR Docket No.: 21-003411
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 Petitioner's request for a hearing.

After due notice, a hearing was held on August 18, 2021. [redacted], Petitioner's mother and guardian, appeared and testified on Petitioner's behalf. John Lambert, Appeals Review Officer, appeared on behalf of Respondent, Michigan Department of Health and Human Services (MDHHS or Department). Jessica Reich, Medicaid Utilization Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for bilateral foot inserts?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary, born [redacted] 2005, who has been diagnosed with bilateral foot pain, other acquired deformities of unspecified foot, and collapsed arches (flat foot). (Exhibit A, pp 8, 22-23; Testimony).

2. On June 28, 2021, the Department received a prior authorization request from Petitioner's provider for bilateral foot inserts. (Exhibit A, pp 19-26; Testimony).

3. On July 6, 2021, the Department sent Petitioner a Notification of Denial indicating that the prior authorization request for bilateral foot inserts was denied for failure to meet policy requirements. (Exhibit A, pp 17-18; Testimony).

4. On July 21, 2021, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, pp 4-10; Testimony).

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 statutes, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM). Regarding the specific request in this case, the applicable version of the MPM states in part:

> **SECTION 1 – PROGRAM OVERVIEW**
>
> This chapter applies to Medical Suppliers/Durable Medical Equipment and Orthotists/Prosthetists.
>
> Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. (Refer to the General Information for Providers chapter for additional information.)
>
> The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.
>
> The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.
>
> This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and Michigan Department of Health and Human Services (MDHHS) includes both the Medicaid and CSHCS Programs unless otherwise noted.
>
> Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics.

Below are common terms used throughout this chapter:

* * *

Orthotics Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to:

- Improve and/or restore the beneficiary's functional level.
- Prevent or reduce contractures.
- Facilitate healing or prevent further injury.

* * *

1.6 MEDICAL NECESSITY

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need 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, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS, NP or PA. 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 MDHHS 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 MDHHS 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 safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.

- The function of the service/device:

  - meets accepted medical standards, practices and guidelines related to:

    - type,

    - frequency, and

    - duration of treatment; and

  - is within scope of current medical practice.

- 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, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.

- The service/device meets the standards of coverage published by MDHHS.

- 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.

MDHHS does not cover the service when Medicare determines that the service is not medically necessary.

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.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

* * *

2.23 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.

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.[1]

Here, the Department sent Petitioner written notice that the prior authorization request for bilateral foot inserts was denied on the basis that, per the above policy, the inserts were not a covered item.

The Department's witness testified that the bilateral foot inserts were denied per the above policy because the medical documentation submitted by Petitioner's provider indicates that Petitioner's chief complaint is flat feet and policy clearly states that Medicaid does not cover foot orthotics for flat feet. The Department's witness indicated

[1] Medicaid Provider Manual, Medical Supplier, July 1, 2021, pp 1-2, 9-10, 68.

that Petitioner's provider could submit a new prior authorization request that focused on other foot diagnoses Petitioner has as opposed to flat feet and the Department would review the request.

Petitioner's mother testified that Petitioner has size 16 feet and that his feet give him problems and cause significant pain.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request in this case. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information that was available at the time the decision was made.

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that the Department's decision must therefore be affirmed. Based on the information provided, the Department properly determined that the bilateral foot inserts were being requested, at least partly, for flat feet. As indicated above, policy does not cover foot orthotics for flat feet. Petitioner is free to ask his provider to submit a new prior authorization request that meets the medical necessity requirements of Medicaid policy. However, based on the information available with the original request, the denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Petitioner's prior authorization request for bilateral foot inserts.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

CA/dh

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact	Gretchen Backer 400 S. Pine, 6th Floor PO Box 30479 Lansing, MI 48909
DHHS Department Rep.	M. Carrier Appeals Section PO Box 30807 Lansing, MI 48933
Petitioner	[redacted] MI [redacted]
Agency Representative	John Lambert MDHHS Appeals Section PO Box 30807 Lansing, MI 48909