[redacted]
[redacted], MI [redacted]

Date Mailed: February 4, 2022
MOAHR Docket No.: 21-005700
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* and upon a request for a hearing filed by Petitioner.

After due notice, a telephone hearing was held on January 26, 2022. [redacted] Petitioner's mother and legal guardian, appeared and testified on Petitioner's behalf. Florence Scott-Emuakpor, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (DHHS or Department). Jessica Wright, Medicaid Utilization Analyst, testified as a witness for the Department.

During the hearing, Petitioner's representative submitted a letter from Petitioner's doctor that was admitted into the record as Exhibit #1, pages 1-3.[1] The Department also submitted one evidence packet/exhibit that was admitted into the record as Exhibit A, pages 1-25.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for custom 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's representative indicated that she also submitted a second letter from a medical provider, but neither Respondent nor the undersigned Administrative Law Judge had received it. Moreover, the undersigned Administrative Law Judge further determined that, even if another letter had been submitted, the hearing could proceed without it and the record need not be left open given the date of the letter and its lack of relevancy.

1. Petitioner is a [redacted] year-old Medicaid beneficiary who has a legal guardian. (Exhibit A, pages 12-14).

2. On November 19, 2021, the Department received a prior authorization request for custom bilateral foot inserts submitted on Petitioner's behalf by her doctor. (Exhibit A, pages 14-21).

3. The medical documentation submitted along with the request identified Petitioner's diagnoses as including proration of both feet; valgus deformity of both great toes; acquired pes planus of right foot; bunions; hallux valgus; pens planus medial column collapse. (Exhibit A, pages 14-20).

4. The medical documentation also indicated that, as Petitioner is nonverbal, the doctor cannot assess the character or quality of Petitioner's pain. (Exhibit A, page 16).

5. Petitioner's doctor further recommended that "custom inserts or a Powerstep Pinnicle to support the medial eminence." (Exhibit A, page 20).

6. On November 30, 2021, the Department sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 21-22).

7. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Sections 1.6 and 2.23 of the Medical Supplier chapter of the Medicaid Provider Manual. Specifically:
>
> - Medical Supplier 1.6: Medical devices are covered if they are the most cost-effective treatment available 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's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it was signed but the treating physician. 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 Supplier 2.23: 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.

Exhibit A, pages 21-22

8. On December 21, 2021, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the complete request for hearing filed in this matter regarding that denial. (Exhibit A, pages 6-13).

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) and, in part, the applicable version of the MPM states:

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.

1.6.A. PRESCRIPTION REQUIREMENTS

A prescription must contain all of the following:

- Beneficiary's name;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number or Social Security Number (SSN) (if known);
- Prescribing physician's, NP’s or PA’s name, address, and telephone number;
- Prescribing physician's, NP’s or PA’s signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the service is needed; and
- Start date of order if different from the physician's, NP’s or PA’s signature date.

The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes, but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or healthcare practitioner's signed documentation.

* * *

1.6.C. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.6.D. CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

A CMN must contain all of the following:

- Beneficiary's name and address;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number (if initiated by the provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different

from the prescription date);

- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements section and the Face-to-Face (F2F) Visit Requirements subsection of this chapter.

MDHHS will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.

Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item.

* * *

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 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.

MPM, October 1, 2021 version
Medical Supplier Chapter, pages 9-12, 68-69

Here, the Department's witness testified that Petitioner's prior authorization request was denied pursuant to the above policies. Specifically, she noted that, while Petitioner has been diagnosed with pes planus and hallux vulgus, the applicable policies expressly provide inserts are not covered for those conditions. She also noted that Petitioner's doctor recommended custom inserts or a Powerstep Pinnicle, and that nothing indicated

that Petitioner had tried that other recommended option as required prior to requesting inserts.

In response, Petitioner's representative testified that, since the request in this case, Petitioner has tried the Powerstep Pinnicle and that it did not help. She also testified that, while Petitioner has been diagnosed with pes planus and hallux vulgus, the inserts are still medically necessary given Petitioner's other conditions and extreme disabilities, including nonverbal autism. Petitioner's representative further testified that the inserts are by far the most cost-effective option as the alternative is to have Petitioner undergo expensive surgery.

The Department's witness then testified that, while the prior authorization in this case contained little of the information provided by Petitioner's representative in her testimony, Petitioner's representative and doctor could submit a new request for bilateral foot inserts along with that information if they chose and seek an exception to the applicable policy.

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

Given the record and applicable policies in this case, Petitioner has failed to meet her burden of proof and the Department's decision must therefore be affirmed. The above policy expressly provides that bilateral foot inserts are not covered for the conditions of pes planus and hallux vulgus, and it is undisputed in this case that Petitioner has been diagnosed with both conditions and seeks the inserts to relieve them. Moreover, while Petitioner's representative testified regarding other issues that affect Petitioner and that could be the basis for an exception to the applicable policy, the prior authorization request submitted to the Department did not identify any such issues and the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information available at the time the decision was made.

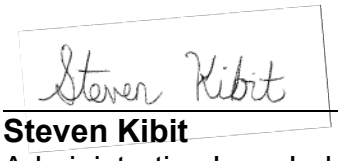
To the extent Petitioner has additional or updated information to provide regarding her need for custom bilateral foot inserts, then her guardian and doctor can always request them again in the future along with that information. With respect to the decision at issue in this case however, the Department's decision must be affirmed given the available information and applicable polices.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS, THEREFORE, ORDERED that:

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



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Steven Kibit
Administrative Law Judge

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

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