[redacted]
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Date Mailed: June 12, 2023
MOAHR Docket No.: 23-002538
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on June 8, 2023. [redacted] the minor Petitioner's mother, appeared and testified on Petitioner's behalf. Leigha Burgdoff, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Jessica Reich, Departmental Analyst, testified as a witness for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-25. Petitioner did not submit any proposed exhibits.

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 minor who is enrolled as a Medicaid beneficiary. (Exhibit A, page 19; Testimony of Petitioner's representative).

2. On April 12, 2023, the Department received a prior authorization request for bilateral foot inserts submitted on Petitioner's behalf by a medical supplier. (Exhibit A, pages 13-17).

3. The Orthosis Evaluation included as part of that request indicated that Petitioner had been diagnosed with "Congenital pes planus bilateral." (Exhibit A, page 13).

4. The attached Durable Medical Equipment Order likewise indicated that Petitioner had been diagnosed with "Congenital pes planus, left foot," and "Congenital pes planus, right foot." (Exhibit A, page 16).

5. No other diagnoses were identified. (Exhibit A, pages 13-17).

6. On April 24, 2023, the Department sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 11-12).

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, page 11

8. On May 8, 2023, 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 6-10).

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.

* * *

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, April 1, 2023 version
Medical Supplier Chapter, pages 9-10, 68-69

Here, as discussed above, the Department denied Petitioner's request for bilateral foot inserts.

In support of that decision, the Department's Departmental Analyst testified that Petitioner's prior authorization request was denied pursuant to the above policies and on the basis that she did not meet the applicable standards of coverage. Specifically, the Departmental Analyst noted that, while Petitioner has been diagnosed with pes planus, the applicable policies expressly provide that inserts are not covered for that condition. She also noted that Petitioner's representative and doctor could submit a new request for bilateral foot inserts if they had additional information to provide.

In response, Petitioner's representative testified that Petitioner has more reasons than just pes planus for needing the requested orthopedic footwear and that the Department should have investigated further before making its decision. She also testified that she attached a letter from Petitioner's doctor to the request for hearing, and that she could not explain why the doctor did not report Petitioner's other medical problems when making the prior authorization request earlier. Petitioner's representative further testified that the Department should not be practicing medicine or contradict medically necessary services prescribed by Petitioner's treating physician.

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 condition of pes planus, and it is undisputed that the prior authorization in this case identified that diagnosis alone as the basis for the request. Accordingly, the requested items are non-covered in these circumstances, and the Department properly denied Petitioner's request pursuant to the applicable standards of coverage. Petitioner's representative may disagree with that policy, but the undersigned Administrative Law Judge is bound by it in making his decision.

Moreover, while Petitioner's representative testified regarding other issues that affect Petitioner; and that could be the basis for the bilateral foot inserts, 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's representative has additional or updated information to provide regarding Petitioner's need for bilateral foot inserts, then she and Petitioner's 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 policies.

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.**

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties and/or attorneys, to their last-known addresses in the manner specified below, this 12th day of June 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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