



Date Mailed: October 20, 2025
Docket No.: 25-027741
Case No.: [REDACTED]
Petitioner: [REDACTED]

[REDACTED]
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This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: October 20, 2025

Docket No.: 25-027741

Case No.: [REDACTED]

Petitioner: [REDACTED]

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 September 17, 2025. Petitioner appeared on his own behalf. Leigha Klaver, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (DHHS or Department). Jessica Reich, Medicaid Utilization Analyst, testified as a witness for the Department.

Exhibits:

Petitioner	1. Pictures
Department	A. Hearing Summary

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 is a Medicaid beneficiary. (Exhibit A; Testimony.)
2. On June 17, 2025, the Department received a prior authorization request for custom bilateral foot inserts submitted on Petitioner's behalf by his doctor. (Exhibit A; Testimony.)
3. The medical documentation submitted along with the request identified Petitioner's diagnoses as including other acquired deformities of both the left and right foot. (Exhibit A; Testimony.)
4. On July 2, 2025, the Department sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A; Testimony.)

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5. 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, 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 was signed by 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 2.24: 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.³

6. On August 5, 2025, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the complete request for hearing filed in this matter regarding that denial. (Exhibit A.)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social

³ Exhibit A, pp 9-10.

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

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, 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 was signed by 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 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.

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- 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;

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- 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.

* * *

2.24 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	<p>Orthopedic shoes and inserts may be covered if any of the following applies:</p> <ul style="list-style-type: none"> ▪ 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). <p>Surgical Boots or Shoes may be covered to facilitate healing following foot surgery, trauma or a fracture.</p>
Noncovered Items	<p>Shoes and inserts are noncovered for the conditions of:</p> <ul style="list-style-type: none"> ▪ Pes Planus or Talipes Planus (flat foot) ▪ Adductus metatarsus ▪ Calcaneus Valgus ▪ Hallux Valgus <p>Standard shoes are also noncovered.</p>

Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> ▪ 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. <p>CSHCS requires a prescription from an appropriate pediatric subspecialist.</p>
PA Requirements	<p>PA is not required for the following items if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ➤ 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

	<p>Foot Amputation)</p> <p>➤ Bilateral, Complicated (Partial Foot Amputation)</p> <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ 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. ⁴

*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, the documentation did not substantiate the orthotics were medically necessary.

In response, Petitioner testified he had received orthotics in the past and did not understand why he was being denied. Furthermore, Petitioner indicated the orthotics would help him avoid surgery on his knees.

The Department’s witness then testified that a letter of medical necessity that explains the whole picture (what the deformities are and what the functional limitations are without the orthotics) would be beneficial in meeting the medical necessity criteria.

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.

⁴ MPM, Medical Supplier, July 1, 2025, pp 9-12, 68-69.

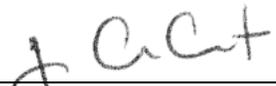
Given the record and applicable policies in this case, Petitioner has failed to meet the burden of proof; and the Department's decision must therefore be affirmed.

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**.



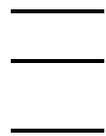
COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at <https://irs.michbar.org> or Michigan Legal Help at <https://michiganlegalhelp.org>. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
Michigan Office of Administrative Hearings and Rules
Rehearing/Reconsideration Request
P.O. Box 30639
Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.



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