

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

██████████,

Appellant

_____ /

**Docket No. 2010-25096 PA
Case No. ██████████**

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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Ms. ██████████, mother and Guardian, appeared as the Appellant's representative. Mr. ██████████, father, and Ms. ██████████, Case Manger Community Care Givers, appeared as witnesses for the Appellant. Ms. ██████████, Appeals Review Officer, represented the Department. Ms. ██████████, Prior Authorization for Michigan Medicaid, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a high frequency chest wall oscillation unit?

FINDINGS OF FACT

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

1. The Appellant is a ██████████ Medicaid beneficiary who has been diagnosed with Distal Deletion of the long arm of Chromosome #6 resulting in significant mental and physical impairments. (Exhibit 1, pages 4-5)
2. On ██████████, the Department received a prior approval-request for a high frequency chest wall oscillation unit for the Appellant. (Department Exhibit 1 pages 8-9)

3. Medicaid policy limits coverage of a high frequency chest wall oscillation unit to the narrow circumstance of a diagnosis of ██████████ and when all other treatment modalities have not been effective. (Medicaid Provider Manual, Medical Supplier Section, 2.15 High Frequency Chest Wall Oscillation Device, Standards of Coverage, October 1, 2009, page 33)
4. On ██████████, the Department denied the prior authorization request because this item is not covered for the Appellant's diagnosis. (Department Exhibit 1, page 7)
5. On ██████████, the State Office of Administrative Hearings and Rules received the hearing request filed on the Appellant's behalf. On ██████████, the hearing request was re-submitted with documentation of Guardianship. (Department Exhibit 1, page 3)

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.

The Standards of Coverage for a group 2 Support surface can be found in the Medical Supplier section of the Medicaid Provider Manual:

2.15 HIGH FREQUENCY CHEST WALL OSCILLATION DEVICE

Definition

A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mobilization, and facilitates it along toward central airways.

Standards of Coverage

A HFCWO system may be covered up to four months if both of the following apply:

- Diagnosis of Cystic Fibrosis, and
- All other treatment modalities have not been effective.

Documentation

Documentation must be less than 180 days old and include:

- Diagnosis pertaining to the need for this unit.
- Severity of condition (e.g., frequency of hospitalizations, pulmonary function tests, etc.).
- Current treatment modalities and others already tried.
- Plan of care by the attending Cystic Fibrosis (CF) Center specialist substantiating need for the device is **required under the CSHCS Program**.
- For continuation beyond the initial four months, the following information must be provided:
 - Documentation of client compliance through the review of equipment use logs; and
 - Medical statement from a CF Center Specialist substantiating the continued effectiveness of the vest is **required under the CSHCS program**.

PA Requirements

PA is required for all requests.

Payment Rules

The HFCWO system chest compression generator system is considered a **capped rental** item and is inclusive of the following:

- All accessories necessary to use the equipment except for the vest itself. This may be separately reimbursed during the initial rental period.
- Education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs and replacements to make the equipment functional.

*MDCH Medicaid Provider Manual,
Medical Supplier Section 2.15,
October 1, 2009, pages 33-34.*

In the present case, the Department determined that that the submitted medical documentation did not meet the standards of coverage. Specifically, the Department Manager testified that there is no medical documentation that the Appellant has a diagnosis of ██████████. The Department Manager explained that policy limits coverage to a diagnosis of ██████████ with failure of all other treatment modalities.

The Appellant's mother disagrees with the Department's denial and explained that the Appellant has a trach, is on oxygen 24/7, receives breathing treatments and is on a ventilator 15 hours a day. (Testimony and Exhibit 1, page 4) The Appellant's mother testified that the Appellant gets pneumonia frequently and has had three hospitalizations for pneumonia since ██████████. The Appellant's mother testified that they have tried all other treatments, but they were not effective. The Appellant's mother notes that the cost of using the vest to prevent the Appellant from developing

Docket No. 2010-25096 PA
Decision & Order

pneumonia is far less than the cost of a hospitalization to treat pneumonia. The Case Manager testified that the treatment the Appellant receives is similar to the treatment a [REDACTED] patient would receive.

The Appellant's mother raised valid issues and concerns. However, this ALJ is limited to reviewing the action taken by the Department under the applicable Medicaid policy. Based on the evidence, the Appellant did not meet the Medicaid standards of coverage for a high frequency chest wall oscillation unit. The Appellant suffer from a genetic disorder has caused the multiple episodes of pneumonia and respiratory distress. Medicaid policy only allows for coverage with a diagnosis of [REDACTED] and does not allow for an exception in cases where there is an equivalent diagnoses or treatment. This does not mean that the Appellant would not benefit from the requested unit or that she is not deserving of it, but only that the Medicaid policy does not allow for coverage in the Appellant's circumstances. Accordingly, the Department's denial must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for a high frequency chest wall oscillation unit.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [REDACTED]

Date Mailed: 6/14/2010

Docket No. 2010-25096 PA
Decision & Order

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.