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:

[redacted]

Appellant

_____/

Docket No. 2010-25100 PA
Case No. [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on his own behalf. [redacted], Appeals Review Officer, represented the Department. [redacted], RN Utilization Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's request for prior authorization for a wearable cardiac defibrillator rental?

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 had no insurance at the time of his [redacted] hospitalization. (Appellant Testimony and Exhibit 1, page 21)

2. The Appellant applied for Medicaid to cover his [redacted] hospitalization. (Appellant Testimony)

3. The medical supply company placed the wearable cardiac defibrillator with the Appellant prior to his discharge from the hospital in [redacted] [redacted] (Appellant Testimony and Exhibit 1, page 10)

4. The medical supply company picked the wearable cardiac defibrillator up from the Appellant at his work within a month of the hospital discharge. (Appellant Testimony)

5. In [redacted], the Appellant's Medicaid application was approved with retroactive coverage to [redacted]. (Appellant Testimony)

6. On [redacted], the Department received a prior authorization request from the medical supply company for a 3 month rental of a wearable cardiac defibrillator for the Appellant. (Exhibit 1 pages 20-22)

7. The prior authorization request did not state what months the rental period would cover but the attached medical order and hospital records were from [redacted] (Exhibit 1, pages 20-22 and 24-41)

8. On [redacted], the Department denied the prior authorization request on the basis that the wearable cardiac defibrillator was not a covered item. (Exhibit 1, pages 18-19)

9. On [redacted] the State Office of Administrative Hearings and Rules received the Appellant's hearing request. (Exhibit 1, pages 4-16)

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.

SECTION 8 - PRIOR AUTHORIZATION

8.1 GENERAL INFORMATION

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements.

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8.2 PROCESSING REQUESTS

Based on documentation submitted, the PA request is approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter or a copy of the PA form, whichever is applicable. Providers

must immediately notify the beneficiary of the approval or denial of the PA request.

Approval of a PA request does not verify beneficiary eligibility. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

8.2.A. VERBAL PRIOR AUTHORIZATION

If a service requires PA but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request PA by calling the MDCH Program Review Division. (Refer to the Directory Appendix for contact information.)

If the service is required at a time when MDCH cannot be contacted, the provider may perform the service and call MDCH by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written PA request (with supporting documentation) to MDCH. If the supporting documentation matches the information relayed for verbal authorization, MDCH sends an approval to the provider.

8.2.B. APPROVAL

Payment is made only for services provided during the period of time the PA is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The prior authorized service must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Program Review Division should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized, and that service also requires PA which was not obtained or is not covered by Medicaid, the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.C. DENIAL

If PA for the service is denied, it must not be billed to Medicaid. The beneficiary will be sent a copy of the denial with an explanation of his appeal rights. Once

notified of the denial, the beneficiary may still wish to receive the service. The provider must reiterate to the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.D. REIMBURSEMENT

For most providers, procedure codes that do not have an MDCH established fee screen, or need special pricing, require documentation be sent with the claim. For some types of services, the special pricing review is completed through the PA process. If a PA is returned with an approved fee, no documentation is required with the claim. If the PA is returned without an approved fee and instructions to bill under a not otherwise classified (NOC) code, documentation must be submitted with the claim.

Medicaid does not provide reimbursement if:

- The beneficiary was not eligible for Medicaid on the DOS. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For customized equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- A service that is prior authorized and rendered in conjunction with another service that requires PA, and PA for the second service was not obtained.
- PA was required but was not obtained.
- The beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- It was determined that PA was obtained after the service was rendered. (The provider should refer to the Verbal Prior Authorization subsection above for an exception to this situation.)
- The service/product was ordered or prescribed by a provider who has been sanctioned, and the sanction was effective before PA was granted.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

MDCH Medicaid Provider Manual, General Information for Providers Section, October 1, 2009, pages 14-15.

1.7.C. RETROACTIVE PRIOR AUTHORIZATION

Services provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and the eligibility was made retroactive. If MDCH's record does not show that retroactive eligibility was provided, then the request for retroactive PA will be denied.

MDCH Medicaid Provider Manual, Medical Supplier Section, October 1, 2009, page 8.

1.11 CHARGING THE BENEFICIARY

The provider may not charge the beneficiary for failure to provide sufficient documentation to support coverage or failure to obtain PA. The provider may charge the beneficiary if the beneficiary waives his right to PA. The provider must maintain on file a document that demonstrates that the beneficiary knew and understood that the waiver of PA would result in the beneficiary's responsibility for payment. In addition, the provider may not charge the beneficiary any co-payments (unless permitted by Medicaid) or charges above the Medicaid allowable amount.

MDCH Medicaid Provider Manual, Medical Suppler Section, October 1, 2009, page 16.

In the present case, the prior authorization request was denied by the Department on [redacted] as a non-covered item. (Exhibit 1, pages 18-19) The Medicaid provider manual refers medical suppliers to the MDCH Medical Supplier Database for specific procedure codes that are not covered. *MDCH Medicaid Provider Manual, Medical Suppler Section, 1.10 Noncovered Items, October 1, 2009, pages 14- 16.* The Department witness testified that the service code for the wearable cardiac defibrillator, K0606, is listed not in the MDCH procedure code database and therefore would require prior authorization. The Department witness testified the request was reviewed by a physician medical consultant for the Department, who determined there was insufficient information to support the request.

In the prior authorization request, the medical supply company stated the wearable cardiac defibrillator would be needed for three months, but did not specify which three months the rental period would cover. (Exhibit 1, pages 20-22) Based upon the Medical Order form, hospital records and the Appellant's testimony, it is likely that the medical supply company was requesting coverage for the device placed in [redacted] (Exhibit 1, pages 10 and 21-41) However, the submitted prior authorization request does not indicate it is a retroactive request. There was also no indication that a verbal prior authorization was previously obtained and the Department witness testified that there is no record of a verbal prior authorization. Additionally, it is not clear why the medical supply company is requesting three months of rental coverage given the Appellant's credible testimony that the device was returned to the medical supply company within one month from discharge.

This Administrative Law Judge must uphold the Department's denial of the Appellant's request. The medical supply company did not indicate what months the wearable cardiac defibrillator would be needed for, nor that the prior authorization was a request for retroactive coverage. Under the prior authorization policy, the medical supply company may not charge the Appellant for failure to provide sufficient documentation to support coverage or failure to obtain prior authorization unless they have documentation that the Appellant waived his right to prior authorization.

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 rental of a wearable cardiac defibrillator.

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: 6/3/2010

***** 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.