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. 2010-41457 QHP
[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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], represented herself. [redacted], Grievance Supervisor, represented the Medicaid Health Plan (MHP), [redacted]. [redacted], RN/Quality Review Specialist, and [redacted], Executive Medical Director, appeared as witnesses for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a CPap Machine?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted] Medicaid beneficiary, who was evaluated at [redacted] for Sleep & Alertness in a sleep study. (Exhibit 1, page 7)

2. A sleep study was performed on [redacted], resulting in a diagnosis of moderate obstructive sleep apnea, as well as other sleep disorders. The Appellant experienced 12.8 events per hour of sleep during the study. (Exhibit 1, pages 8-10)

3. The Appellant does not take any medications that would alter his sleep architecture. (Exhibit 1, page 8)

4. On [redacted] a second sleep study was conducted with the Appellant wearing the CPap machine, and the Appellant experienced only .1 events per hour of sleep. (Exhibit 1, pages 12-14)

5. On [redacted], the MHP received a request for a CPap machine for the Appellant from [redacted]. (Exhibit 1, page 6)

6. On [redacted], the MHP denied coverage for a CPAP machine and sent the Appellant notice of non-coverage. The denial was based on lack of medical documentation. Specifically, the MHP needed doctor's office notes to show a history of high blood pressure, heart disease, stroke, or use of oxygen. (Exhibit 1, pages 17-19)

7. On [redacted], the Appellant filed a Request for Hearing with the State Office of Administrative Hearings and Rules. (Exhibit 1, page 10)

8. The Appellant's hearing request was treated as an internal appeal by the MHP, and a hearing was conducted on [redacted]. (Exhibit 1, pages 21-22)

9. On [redacted], the Appellant's appeal was denied because the medical documentation accompanying the request did not support that the Appellant met the required criteria for a CPap machine. Specifically, there was no documentation to support that the Appellant has a related symptom, such as hypertension, ischemic heart disease, history of stroke, or morbid obesity.

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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified MHPs.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if

services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract,
October 1, 2009.

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual states as follows:

2.10 CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE

Standards of Coverage-

A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following:

- Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or
- AHI documents 5 to 14 events per hour with related symptoms such as:
  - Excessive daytime sleepiness, impaired cognition, mood disorders; and/or
  - Hypertension, ischemic heart disease, or history of stroke, or morbid obesity.

For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.

Documentation –

Documentation must be less than 90 days old and include:

- Diagnosis and/or medical condition related to the need for the CPAP device.
- A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep.
- For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary

has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted.

- Prescription from an appropriate pediatric subspecialist is required for coverage under the CSHCS Program.

PA Requirements –

PA is not required if the Standards of Coverage are met and:

- The beneficiary is over the age of 21 and has one of the following diagnoses:
  - Obstructive Sleep Apnea (Adults)
  - Tracheostomy Complications
  - Tracheomalacia
  - Other Anomalies of Larynx, Trachea, and Bronchus
  - Insomnia With Sleep Apnea
  - Hypersomnia With Sleep Apnea
  - Other and Unspecified Sleep Apnea
- For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea.
- The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist.

PA is required for:

- Medical need beyond the Standards of Coverage.
- Replacement within five years.

PA is given for the initial four months and then for the final six months.

Payment Rules –

A CPAP device is considered a capped rental item and is inclusive of the following:

- All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, etc.)
- Education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs or replacements to make the unit functional.

> After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPAP mask should be considered prior to replacement of entire mask.)
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Medical Supplier*
> *Version Date: April 1, 2010, Pages 26-27*

The MHP's criteria for approval of a CPap machine is consistent with the Medicaid Provider Manual. However, the MHP requires specific documentation to support the related symptoms.[1.]

Here, the Appellant experienced 12.8 events per hour. Therefore, in order to satisfy the MHP criteria, he must have related symptoms that are documented. Related symptoms include excessive daytime sleepiness, impaired cognition, mood disorders, hypertension, ischemic heart disease, history of stroke, or morbid obesity.

The Appellant testified that he is still having problems sleeping, i.e., he sleeps in his recliner because he cannot lay flat to sleep. When asked if he had any of the required related symptoms, he stated that he wears a Lidoderm pain patch everyday and that he has suffered three strokes—two in 2007 and one in 2008. Unfortunately, he did not provide any medical documentation to support his testimony.

Further, while the MHP's Executive Medical Director acknowledged that the sleep study report noted that the Appellant suffers from excessive daytime sleepiness and hypertension, he pointed out that the report was both internally inconsistent, as well as inconsistent with information obtained from the Appellant's physician. More specifically, the report itself states that excessive daytime sleepiness is indicated by an Epworth sleepiness score that is greater than 10. Here, the Appellant's score is 8. Therefore, he does not suffer from excessive daytime sleepiness. Likewise, while the report indicates that the Appellant has hypertension, his physician's office stated that his blood pressure was 120/78 at his last visit, and the Appellant has not filled any prescriptions for high blood pressure yet this year.

The Appellant did not satisfy his burden of proving that the MHP improperly denied him coverage or that he met the standards of coverage for the CPap machine. However, should the Appellant obtain documentation of his related symptoms, he may re-submit his request at any time.

1 For example, excessive daytime sleepiness must be documented by either an Epworth score or a Multiple Sleep Latency Test.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the CPap machine was proper.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/30/2010

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.