STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-50159 PA
Case No. [redacted]

Appellant
_____/

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], the Appellant, appeared on her own behalf. [redacted], Appeal Review Manager, represented the Department. [redacted], Consulting Physical Therapist, appeared as a witness for the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a shoulder continuous passive motion chair?

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 [redacted] year old Medicaid beneficiary who underwent surgery for torn supraspinatus, torn upper subscapularis, partial biceps tendon rupture, impingement, and AC joint DJD, right shoulder. (Exhibit 1, page 4)

2. On [redacted], the Department received a prior approval-request for a shoulder continuous passive motion machine for the Appellant. (Exhibit 2, pages 1-3)

3. In [redacted], the Department requested additional information from the Appellant's doctor, specifically a prescription and a letter of medical necessity with a specific reason for an exception for this treatment as it is not a standard of care established by CMS (Medicare/Medicaid). (Exhibit 2, page 1)

4. On [redacted], the prior authorization request was re-submitted with additional documentation. (Exhibit 1, pages 3-13)

5. On [redacted], the Department denied the prior authorization request because medical necessity had not been established. (Exhibit 1, pages 2 and 14-15)

6. On [redacted], the Michigan Administrative Hearing System received the Appellant's hearing request. (Exhibit 1, page 2)

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 Medicaid Provider Manual addresses medical necessity:

> **1.5 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's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is 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 MDCH standards of coverage.
>
> Medical equipment may be determined to be medically necessary when all of the following apply:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or 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.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.
- It is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order.
- It meets the standards of coverage published by MDCH.
- 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.

MDCH Medicaid Provider Manual,
Medical Supplier Section
April 1, 2011, pages 4-5

In the present case, the Department initially received the prior authorization request for a shoulder continuous passive motion machine for the Appellant on [redacted]. (Exhibit 2) The Department requested additional information in [redacted] but it is not clear that the date on the letter requesting additional information is when it was actually issued. The Request for Additional Information letter is dated [redacted], but this is earlier than the date the consultant signed the review action and remarks, [redacted]. (Exhibit 2, page 1-2) The Request for Additional Information specified that the Department needed a prescription and letter of medical necessity with a specific reason for an exception for this treatment as it is not a standard of care established by CMS (Medicare/Medicaid). (Exhibit 2, page 1) The Consulting Physical Therapist testified the Department requested the physician's post operative protocol, but it was not received. However, this was not specifically included on the [redacted] Request for Information, and no subsequent Request for Additional Information was included in the evidence. (Consulting Physical Therapist Testimony and Exhibit 2, page 1)

On [redacted], the prior authorization request was re-submitted, with additional documentation. (Exhibit 1, pages 3-13) A letter of medical necessity was submitted, indicating the shoulder continuous passive motion machine is needed to prevent

stiffness, edema, inflammation, and accumulation of scar tissue and the need for additional surgery in the future. The continuous passive motion therapy would promote healing and prevent joint stiffness and edema while improving range of motion, tissue healing, and prevent scarring of tendon, cartilage, and ligament. The Appellant's range of motion was listed as forward elevation to 160 degrees, abduction to 150 degrees, external rotation at 90 degrees of abduction to 45 degrees, and posterior internal rotation at the level of T10. (Exhibit 1, page 4) The range of motion appears to have been copied over from a pre-surgery office note. (Exhibit 1, pages 4 and 6) The Consulting Physical Therapist testified that the listed range of motion is within functional limits. She stated that with this pre-operative range of motion and standard post-operative physical therapy, there should not be any limitation that would require an additional piece of equipment such as the shoulder continuous passive motion unit. (Consulting Physical Therapist Testimony)

The Consulting Physical Therapist referenced the above cited Medicaid Provider Manual policy for medical necessity. She indicated the denial was primarily based on not being within accepted medical standards/practice guidelines and the most cost effective treatment available. The Consulting Physical Therapist stated she could not see any reason why use of the requested shoulder continuous passive motion chair would shorten the course of physical therapy and it is not a generalized evidence based practice to use this chair. Rather, it is only outside the standard of care to not use the requested chair if an open rotator cuff repair was performed. (Consulting Physical Therapist Testimony) The submitted operative note documents that the Appellant underwent an arthroscopic procedure. (Exhibit 1, page 7)

The Appellant testified that the surgery was not just for her rotator cuff, but also for her bicep. Her testimony indicated that she used the chair for four weeks post surgery, then began physical therapy on the day they took the chair. The Appellant described her elbow being locked after surgery, weakness in her arm, being unable to grip, and very little range of motion in her whole arm, despite use of the chair. The Appellant testified she also went to occupational therapy. The Appellant indicated she is still in physical therapy, twice a week, and they can move her shoulder, but it is still not where it should be. (Appellant Testimony)

The Consulting Physical Therapist testified that use of the chair would not address strength and range of motion for the whole arm, only range of motion for the shoulder. The Consulting Physical Therapist indicated that this appears to be a slower case and use of the chair did not speed up the Appellant's recovery. (Consulting Physical Therapist Testimony)

Based on the documentation submitted and the Consulting Physical Therapist testimony, medical necessity was not established for prior authorization of the requested shoulder continuous passive motion chair. Accordingly, the Department's denial must be upheld.

However, it should also be noted that under the Medicaid Provider Manual prior authorization policy, the provider 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 her right to prior authorization. MDCH Medicaid Provider Manual, Medical Supplier Section, 1.11 Charging the Beneficiary, April 1, 2011, page 18.

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 shoulder continuous passive motion chair based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/8/2011

***** NOTICE *****
The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.