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. 2011-52687 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 [redacted], the Appellant's mother, represented him. [redacted], Appeal and Review Officer for the Department of Community Health, represented the Department. [redacted] Medicaid Analyst appeared and testified on behalf of the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a stationary suction machine?

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.

2. On [redacted], the Department received the Prior Approval-Request/Authorization form and medical documentation from Metro Companies requesting a replacement suction machine for the Appellant. (Department Exhibit A)

3. The Appellant has undergone a trachestomy and has a medical need for suctioning. (uncontested)

4. The Appellant has use of a portable suction machine. He has had a stationary one in the home as well.

5. The Appellant's mother reports the stationary suction machine is broken and has been broken, thus the family is relying on the portable machine at this time.

6. The Appellant's mother reports the portable machine is losing power.

7. The Appellant's doctor has supplied a letter addressing the need for a second suctioning machine for the Appellant, explaining it is appropriate under the Appellant's medical circumstances.

8. The Department's records indicate a suctioning machine was supplied to the beneficiary in [redacted] and a second one in [redacted].

9. The Department sent a Notice of denial [redacted], citing Medicaid policy allows for replacement of durable medical equipment every 5 years as needed, policy prohibits provision of second units as backups and finally, it is the durable medical equipment supplier's obligation to provide loaner equipment while broken equipment is repaired.

10. On [redacted], the Michigan Administrative Hearing System received the Appellant's hearing request.

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.

> **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.

1.5.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 name, address, and telephone number;
- Prescribing physician's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the service is needed; and
- State date of order if different from the physician'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.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis. (Providers must verify this information by referring to the beneficiary's eligibility letter received from CSHCS.)
- A physician subspecialist must sign the prescription if it is stated as required by the CSHCS Program in the Coverage Conditions and Requirements Section of this chapter.

MDCH reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

1.5.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).

1.5.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 of this chapter.

MDCH 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.

1.6 DOCUMENTATION IN BENEFICIARY FILE

Specific medical device, including the physician's order, the MSA-1656 and the MSA-1653-B, in the beneficiary's file for seven years. For audit purposes, the supplier's records or beneficiary's medical record must contain the prescription and required documentation that substantiates the medical necessity of the item supplied. In addition to the prescription and any applicable documentation required, the provider must maintain on file:

- Equipment use logs or other provider required documentation as stated in the Coverage Conditions and Requirements Section of this chapter under Documentation for the item.
- For items purchased, proof of purchase (e.g., delivery slips, sales slips, vouchers).
- For items rented, set-up slips and pick-up slips with signature of beneficiary or legal representative, and maintenance records.
- For items shipped directly to beneficiary, date of delivery must be maintained in the records with delivery slip. It is the provider's responsibility to replace a service for which the beneficiary states was not received without additional cost to MDCH or beneficiary.
- Proof of education and instruction to beneficiary and/or caregiver regarding the proper usage of equipment and/or supplies when applicable (e.g., delivery slip signed by beneficiary).

1.7 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-fabricated DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and/or the MDCH Medical Supplier Database on the MDCH website.

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screen.
- Medical need for an item beyond MDCH's Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required on the MDCH Medical Supplier Database.

1.7.A. PRIOR AUTHORIZATION FORM

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested

must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must use the specific HCPCS code and the code description. A NOC code may not be used unless the use of a NOC code for the item has been approved by the PDAC. The brand, model, product or part number must be stated on the MSA-1653-B with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the Coverage Conditions and Requirements section of this chapter for additional information regarding standards of coverage and payment rule requirements.)

PA request forms and attached documentation may be mailed or faxed to the MDCH Program Review Division. (Refer to Directory Appendix for contact information.) Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDCH website. (Refer to the Directory Appendix for website information.)

1.8.C. REPAIRS AND REPLACEMENT PARTS [CHANGES MADE 4/1/11 & 10/1/11]

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications**. It is the responsibility of the provider to supply loaner equipment while the beneficiary-owned item is being serviced at no charge to MDCH.** (emphasis supplied) For audit purposes, all suppliers must maintain

> protocols and records defining how the maintenance of equipment is to be achieved.
>
> MDCH will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.
>
> **Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDCH as a rental.**
>
> Version Medical Supplier
> Date: October 1, 2011 Pages 4-14

The Medical Supplier section of the Medicaid Provider Manual also addresses non-covered items in Section 1.10. This specifically includes second units for school use.

In this case, the Department denied the replacement of the stationary suction machine because of the policy requiring medical suppliers to provide loaner equipment when a repair is needed on equipment that has already been supplied and is not due for replacement. The Department records indicate 2 suction machines have been supplied, one in [redacted] and another in [redacted]. The Department witness stated that the one provided in [redacted] was replaced in [redacted]. Should the unit provided in [redacted] require repair, the medical supplier must provide a loaner while the repair is being completed. The Department Analyst stated the Department does not differentiate between portable or stationary units. Furthermore, second units are not customarily provided.

The Appellant's mother stated 2 units are necessary because if the only working one fails, she will have to call an ambulance for her son. She further stated the portable unit is losing power and they use it a lot. She stated the doctor also believes it appropriate to have 2 working units.

This ALJ does not find the policy cited denying second units for school use limits the Department's ability to provide a second unit in this case. The phrase as written in policy states, "second units for school use," not "second units." While it seems obvious to this ALJ that it is inappropriate to extract 2 words from a phrase written into policy to support denial of requested medical equipment, it apparently needs to be stated explicitly. Despite the fact that the cited policy does not prohibit the Department from provision of a second unit should it determine it to be medically necessary, the fact remains the Department has determined the second unit is not medically necessary in this case. The Appellant's doctor does advocate on behalf of the second unit but describes it is appropriate. The Department also cited policy stating a medical supplier must provide a loaner when equipment requires repair. Here, however, the first unit was provided in [redacted], the second in [redacted] Without evidence the unit provided in [redacted]

is the broken unit, there is no reason to believe the medical supplier will undertake to repair a unit provided in [redacted], free of charge. So, again, the policy supplied will not support the assertion from the Department that a repair must be undertaken at cost to the medical supplier. However, if the newer machine is the one in need of repair, the Policy cited does apply to the case and the medical supplier is obligated to undertake the repair while providing a loaner machine for the Appellant's use. Finally, while this ALJ understands the worries and concerns articulated by the Appellant's mother, they are inadequate to establish the Department has reached its conclusion in error. The burden does rest with the Appellant to establish the Department denied the medical equipment in error. Here, there is no cite to policy establishing a Department error resulted in denial of medically necessary medical equipment, nor a right to Medicaid coverage of a second unit, thus despite what this ALJ believes may be prudent, she is without authority to establish a determination based upon anything other than Medicaid policy, thus the Department's determination that a second unit is not medically necessary 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 second suctioning machine.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date mailed: 12/7/2011

***** 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.