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:

Docket No. 2012-21584 PA

[redacted] [redacted] [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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented himself at hearing. Translation services were provided by Interpreter Network, LLC.

The Department of Community Health was represented by [redacted], Appeals and Review Officer. The Department witness was Medicaid Utilization Analyst.

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for an osteogenesis bone growth stimulator?

FINDINGS OF FACT

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

1. The Appellant is an adult Medicaid beneficiary.

2. The Appellant had single level fusion surgery at levels C4-C5 on [redacted]

3. On [redacted] a Medical supply company submitted a prior authorization request to the Department of Community Health requesting authorization for the Appellant to have an osteogenesis bone growth stimulator. Supporting documentation included with the request included an order form, a prescription from [redacted], M.D. ordering an orthofix bone stimulator and Southeast Michigan Surgical Hospital follow up neurosurgical consultation report.

4. The Department completed a review of the request and determined the Appellant did not meet the published criteria for coverage of the requested equipment.

5. On [redacted], the Department denied the prior-authorization request because "this patient does not meet the criteria for the electrical stimulation".

6. 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.

The standards of coverage and documentation requirements for osteogenesis stimulators can be found in the Medical Supplier section of the Medicaid Provider Manual. General provisions also apply to coverage standards.

> **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/DME/Prosthetics and Orthotics Database on the MDCH website.
>
> PA will be required in the following situations:
>
> - Services that exceed quantity/frequency limits or established fee screens.
> - 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 as noted on the MDCH Medical Supplier/DME/Prosthetics and Orthotics 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.)

1.7.B. MOBILITY AND SEATING EVALUATION AND JUSTIFICATION FORM

The Mobility and Seating Evaluation and Justification form (MSA-1656) provides a standard assessment tool for a licensed medical professional to use when performing assessments for wheelchairs, seating systems, and pediatric standing systems. The form is required for all ages and covered settings. (Refer to the Forms Appendix for a copy of the form and form completion instructions.) The MSA-1656 serves as a baseline evaluation for the beneficiary and is a clinical assessment that also includes an assessment of current technology options available to meet the

beneficiary's medical and functional goals. Once problems and goals are determined, the process includes a patient simulation trial using comparable loaner or demonstration technology. The patient simulation is performed jointly by the clinician and a qualified assistive technology practitioner. The initial MSA-1656 is retained on file by MDCH. A new MSA-1656 is not required for additions or revisions to a wheelchair unless there is a change in the beneficiary's functional status. Form completion instructions describe the responsibilities of the treating physician, the physical and occupational therapist, the medical supplier, and the nursing facility staff (when appropriate).

The MSA-1656 must be submitted within 90 days of the date the form is completed. Completion/submission of the MSA-1656 without supporting documentation from the medical record is not acceptable. The use of medical supplier-created mobility forms or "canned" documentation statements are not acceptable and may not be used as a substitute for information from the medical record or for completion of required MDCH forms.

The outpatient therapy provider or the nursing facility may bill for the mobility and seating assessment performed by the licensed medical professional using HCPCS Code 97542.

1.7.C. EMERGENCY PRIOR AUTHORIZATION

A provider may contact MDCH to obtain a verbal PA when the prescribing physician has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain a verbal PA, the provider may call the Program Review Division or fax a request. If the provider chooses to use a PA form to request a verbal authorization, "verbal PA request" must be in box 37 and the physician's name and phone number. (Refer to the Directory Appendix for contact information.)

If an emergency service is required during nonworking hours (i.e., after 4:00 p.m., weekends, and State of Michigan holidays), the provider must contact the Program Review Division on the next available working day.

The following steps must still be completed before an actual PA number is issued for billing purposes:

- Submission of the PA request (MSA-1653-B) to MDCH within 30 days of the verbal authorization. (Include the date of the verbal authorization in Box 37.)
- Submission of the supporting documentation (e.g., prescription and CMN, physician letter, or applicable medical record).

The PA number will not be given for billing MDCH and the provider will not be reimbursed if:

- The beneficiary was not eligible when the service was provided.
- A completed PA request (MSA-1653-B) is not received within 30 days of the verbal authorization.
- Required prescription and documentation is not received.
- The prescription and/or documentation are not signed within 30 days of the effective date.
- The prescription and/or documentation are not received within 30 days of the date of service (DOS).
- The medical need for the service is different than what was verbally given and does not fall within the Standards of Coverage.

1.7.D. 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.

1.7.E. BENEFICIARY ELIGIBILITY

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDCH will not reimburse the provider. To assure payment, the provider must verify eligibility prior to ordering or delivering the service. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

When equipment is prior authorized (if required) and ordered but not delivered before the loss of eligibility, MDCH will pay for the service if the product is delivered within 30 days after the loss of eligibility.

Verbal authorization does not guarantee payment or eligibility.

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2.29 OSTEOGENESIS STIMULATORS

Definition An Osteogenesis Stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a

fracture or fusion site. A multi-level spinal fusion is one which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.). A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal. The stimulator includes, but is not limited to, the osteogenesis stimulator, electrical, noninvasive, other than spinal applications and the osteogenesis stimulator, electrical, noninvasive, spinal applications.

Standards of Coverage

A **nonspinal electrical osteogenesis stimulator** may be covered when other treatment methods have been ineffective and when one of the following applies:

- There is a nonunion of a long bone fracture with radiographic evidence which indicates that the fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator.
- There is a nonunion of a nondisplaced scaphoid fracture.
- If there is failed fusion of a joint, other than in the spine, where a minimum of nine months has elapsed since the surgery.
- Congenital Pseudoarthrosis not due to lack of skeletal maturity.
- The fracture gap is < = 1 cm.
- A nonunion of a long bone fracture is described by ICD-9-CM code 733.82 plus the code for the fracture site: 810.00-810.13, 812.00-813.93, 815.00-815.19, 820.00-821.39, 823.00-824.9, 825.25-825.35.

A **spinal electrical osteogenesis stimulator** may be covered when other treatment methods have been ineffective and when one of the following applies:

- There is a failed spinal fusion (ICD-9-CM code V45.4) where a minimum of nine months has elapsed since the last surgery.
- Following multi-level (three or more vertebrae) spinal fusion surgery (ICD-9-CM code V45.4) without instrumentation.

Clinical indication in cervical spine fusions with instrumentation (reviewed on case by case basis).

Following spinal fusion surgery (ICD-9-CM code V45.4) where there is a history of a previously failed spinal fusion at the same level(s). How long ago was the failure?

□

May also be indicated as an adjunct to high-risk fusion; cases that meet one or more of the following criteria:

- Smoking (cessation attempts)
- Diabetes
- Metabolic disease where bone healing is likely to be compromised Grade III or greater spondylolisthesis.

Non-Covered Conditions

Medicaid does not cover the use of a bone growth stimulator for any of the following indications as it is considered experimental, investigational, or unproven (not all inclusive):

- Fresh fractures (other than when using ultrasound bone stimulation for the tibia or radius)
- Toe fractures
- Sesamoid fractures
- Avulsion fractures
- Osteochondral lesions
- Stress fractures
- Displaced fractures with malalignment
- Synovial pseudoarthrosis
- Fractures related to malignancy
- The bone gap is either > 1 cm or > one-half the diameter of the bone
- Primary surgeries with current internal fixation techniques (i.e., pedical screw fixation and variants)
- Lack of skeletal maturity (refer to congenital pseudoarthrosis)

Documentation

Documentation must be less than 90 days old and include all of the following:

- Diagnosis/medical condition related to the need for the device.
- Alternative treatment methods tried and results.
- For a diagnosis of fracture nonunion, reports of sequential x-ray results for a period of no less than 90 days and office records, including previous treatments and operative procedures (if any).

- For a spinal fusion procedure, pertinent office and/or hospital records as well as a legible, complete description of indications for electrical stimulation. A copy of the operative report(s) may be required.
- Other modalities still to be used (include type and location).

PA Requirements PA is required and evaluated on a case by case basis.

Payment Rules Osteogenesis stimulators are considered a **purchase only** item and are inclusive of the following:

- All accessories needed to use the unit (e.g., electrodes, wires, cables, etc.).
- Education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs or replacement to make the unit functional based on manufacturer warranty.

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In the present case, the information with the prior-authorization request was insufficient to show that the Appellant met the standards of coverage requirements set forth in the policy. The evidence showed he had a single level fusion at C4-C5. The standards of coverage stipulate he may have coverage if he had a multi-level surgery. There is no evidence of record he did so. He did not assert he had a multi level surgery or that he met the standards of coverage at hearing.

At hearing the Appellant, through a translator, testified he did not want the machine but the company brought it to his house anyway. He did state he had surgery and had pain.

This ALJ reviewed all the evidence of record. Neither the testimony nor documentation submitted establishes the Appellant met the standards of coverage criteria set forth in the Policy. 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 requested durable medical equipment.

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: 5-22-12

***** 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.