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. 2012-23390 PA [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 begun [redacted]. It was continued following submission of additional evidence from the Department of Community Health and opportunity for review of same by the Appellant's mother. It was completed [redacted].

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

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for a Rifton Solo Lift Model #R712 and accessories?

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 [redacted]-year-old Medicaid beneficiary.

2. The Appellant requires full assist transfers due to his medical condition. His diagnoses include: spastic quadriplegia and congenital anomalies of skull and face bones. (uncontested)

3. The Appellant is severely cognitively impaired, as well as physically impaired. (uncontested)

4. The Appellant's mother has medical conditions that prohibit her from transferring the Appellant without use of electric lift.(uncontested)

5. Medical supplier [redacted] has submitted a prior authorization request for the Rifton Solo Lift Model #R712 and accompanying accessories, including 2 vests, a power supply cord and charger, on behalf of the Appellant.

6. Accompanying documentation submitted in conjunction with the request for the electric lift includes 1) prescription for the Solo Lift from Doctor's Hospital; 2) Letter of Medical necessity co-signed by a physical therapist and physical therapist assistant dated [redacted]; 3) Itemized billing statement from Rifton Equipment to [redacted] 4) prescription request from Wright and Filippis to the prescribing doctor

7. The Department completed a review of the request and determined the Appellant did not meet the published criteria for coverage of an electric lift; however, not the specific model and accessories requested.

8. On [redacted] the Department denied the prior-authorization request because "1) requested information not received; 2) multiple power lifts are available and were not ruled out as requested; 3) unable to accept evaluations written and/or signed by a PTA. Please refer to Medical Supplier Chapter, Sections 1.5—Medical Necessity, 1.7—Prior Authorization, and 2.20—Lifts (Hydraulic and Electric) of the Medicaid Provider Policy Manual."

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

10. Additional documentation submitted by the Appellant in conjunction with the hearing request includes updated letters of medical necessity from the physical therapist dated [redacted], copy of letter dated [redacted] form the physical therapist, home medication worksheet for the Appellant, letter of medical necessity signed by the M.D. P.T Assistant and P.T., correspondence from [redacted] requesting a Heuer Lift dated [redacted] correspondence from [redacted], M.D. supporting purchase and need for an electric lift dated [redacted] list is not inclusive)

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 electric lifts stimulators can be found in the Medical Supplier section of the Medicaid Provider Manual. General provisions also apply to coverage standards.

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.

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.

1.7 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.

Version Medical Supplier
Date: April 1, 2012 Pages 8- 10

The Medicaid Provider manual sets forth the standards of coverage for the medical equipment sought by the Appellant in this case.

SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

2.20 LIFTS (HYDRAULIC AND ELECTRIC)

Definition Lifts include, but are not limited to, hydraulic and electric, and accessories include slings and/or seats.

Standards of Coverage

A standard **hydraulic lift** may be covered when the beneficiary requires assistance in transfers, provision of the lift will allow the beneficiary to be transferred safely, and one of the two conditions stated below are met:

- The beneficiary requires a one-person assist but the weight or size of the beneficiary prohibits safe transfers or could cause harm to the caregiver.
- The beneficiary requires a two-person assist and there are not two caregivers in the home.
- An **electric lift** may be covered when the above Standards of Coverage are met and the hydraulic lift cannot be used safely or when the beneficiary's medical condition results in increased tone (e.g., spasticity).

Documentation

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

- Diagnosis/condition requiring use of the lift.
- Functional level of assistance required to complete activities of daily living (ADLs).
- Type of transfer required.
- Weight and height of the beneficiary.
- Type of lift requested.
- An occupational or physical therapy evaluation and recommendation.
- Number of caregivers in the home and number of hours during the 24-hour period that each caregiver is present.

PA Requirements

PA is not required if Standards of Coverage are met for**:**

- Hydraulic lifts
- Replacement slings or seats

PA is required for:

- Electric lifts
- Replacement within ten years

Payment Rules

A lift may be a **capped rental** or **purchase** item.

If unit is billed as a capped rental, the rental payment would be inclusive of the following:

- All accessories needed to use the equipment.
- Education on the proper use and care of the equipment.
- Routine servicing and all necessary repairs or replacements to make the unit functional.

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In the present case, the Department stipulates the Appellant meets medical necessity to provide coverage for an electric lift. It is undisputed the Appellant's medical condition and that of his mother, the only caregiver reportedly present in the home, satisfy the criteria set forth to establish an electric lift is necessary. The two parties dispute is whether the requested lift is the only one which satisfies the medical needs of the

Appellant. The Department witness testified there are many lifts that could be covered for the Appellant, and which satisfy his medical needs. The Appellant's mother testified his need for a safe transfer renders the Solo Lift requested as the only electric lift suitable. The Department asserts the other, less costly, lifts available will transfer the Appellant safely, and thus meet his medical needs.

The Solo Lift requested is portable and outfitted with a vest that is placed on the Appellant for transferring him. He is severely impaired and is unable to participate in his own transfer at all. Additionally, he is prone to body movements that he cannot control during the transfer process. His cognitive levels are reportedly in the [redacted] month old range, thus he is not "misbehaving" during transfer, rather, he is unable to make a decision that it is unsafe to thrust his body during a transfer. This is part of his medical condition and is not found to be a behavioral issue in the sense that it is choice of any kind. The Appellant's mother testified she does not feel or believe a safe transfer can be accomplished with an electric that does not use a vest to hold the Appellant.

The Department witness testified the lift sought is not the most cost effective available to meet the medical needs of the Appellant and that medical necessity for the particular lift is not demonstrated by his condition or documentation provided. This ALJ reviewed all the documentation provided carefully and specifically to ascertain if medical necessity for the Solo Lift requested is established. Specifically, this ALJ was looking to see if evidence had been provided stating use of a sling style lift (with securable straps) was identified as unsafe, medically inappropriate or contraindicated for the Appellant. All the correspondence addressing the medical necessity for a lift indicates the lift sought would best meet the Appellant's needs, his family's needs and there is also evidence it is easier to use. There is no direct evidence contradicting the Department's assertion that there are many other lifts which provide for safe transfers. The letter o[redacted] specifically indicates that use of a Hoyer Lift was considered but "[redacted] mother would be unable to use the crank device due to her medical status. She also states that when trialing the Hoyer Lift, [redacted] tends to slide forward in the sling and it is not a safe transfer." This document is signed by a physical therapist and a physical therapist assistant. It is careful not to indicate that either of the two professionals signing the statement is asserting the sling transfer is unsafe. It is attributed specifically to a report from the Appellant's mother. On[redacted] another physical therapist signed correspondence addressing the need for the electric lift. In this letter it is stated "all of the above lifts would be appropriate for [redacted] EXCEPT for the sling design they have. [redacted] does not have the upper body strength and stability required to assist with transfers. His mother has tried the sling design in the past without success. [redacted] slides out of the sling due to the design and his inability to hold on, support some of the weight himself, and he does not have the trunk stability to help him stay in the sling. These options would not be safe for [redacted] or the caregiver." At hearing the Appellant's mother was asked directly if the Appellant had ever been transferred with use of a lift with sling and she answered yes. She was also asked if he had ever actually fallen out of the sling during transfer. She answered no but stressed those are two-person transfers. She did not provide any documentation indicating he had incidents with the sling style lifts and had been injured in the process.

The Department witness provided explicit testimony that the electric lifts with the slings are used for others who are not capable or assisting with their own transfer, have no trunk controls or ability to hold on. She testified the slings are equipped with straps that render the transfer safe. She testified she was fully confident the Department was approving a device that would safely transfer the Appellant and confident the Department was not refusing to provide equipment that was shown to be medically necessary. The Department witness asserted the body movements during transfer are a behavioral issue and medical equipment is not covered to address behavioral issues. She did testify that use of the electric lift with a sling is safe even for this particular Appellant and his needs.

This ALJ considered testimony from the Appellant's mother that the Appellant will thrust his body during transfer and that because of his cognitive limitations he is not aware of the safety risk this poses. The Department's assertion that this is a behavioral issue rather than a medical issue is rejected by this ALJ. There is no evidentiary support for the Department's assertion. This does not establish medical necessity for the Rifton Solo Lift is established, however.

This ALJ is required to consider and apply the published standards and requirements as set forth in the Medicaid Provider Manual. In this case, the assertion that the electric lift which accomplishes transfers with a sling design is an unsafe transfer is not corroborated with sufficient medical evidence to be found reliable. If the transfer accomplished with use of the sling design lifts were unsafe for the Appellant, the medical evidence of this should be quite apparent. Here, the letters submitted are not forthcoming in stating unequivocally that it is unsafe or otherwise medically inappropriate to use an electric lift with a secured sling for transferring the Appellant. The letter submitted [redacted] was considered, however, this does not provide evidence the Appellant has actually managed to slide out of a sling during a transfer when properly secured. Furthermore, the Appellant's mother provided testimony inconsistent with the statement that the Appellant slides out of the sling. She testified while under oath that he had not slid all the way out or fallen out during transfer. She provided no specific example, incident report or hospital report of injuries treated as a result of actually sliding out of a sling during a transfer, thus lending support to the Department's position that it can be done safely and is done safely by others similarly situated. It is indisputable the Appellant is entitled to coverage for the most cost effective means of transferring him safely. His well being (safety) is of utmost concern. This ALJ does specifically rely on the testimony provided by Department witness [redacted] who stated the Appellant would be transferred safely when using a properly secured sling style lift, to find medical necessity for the Rifton Solo Lift Model #R712 is not established.

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 Rifton Solo Lift Model R712 and accompanying accessories.

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.