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. 2012-37600 CL
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]. [redacted], Home Manager, represented the Appellant. [redacted] the Appellant, was also present. [redacted], Appeals Review Officer, represented the Department. [redacted], Michigan Department of Community Health (MDCH) Contract Manager for Diaper and Incontinence Program, appeared as a witness for the Department.

ISSUE

Did the Department properly deny coverage of all incontinent supplies?

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], [redacted], the Department's contractor for the Diaper and Incontinent Supplies Program, received a prescription for pull-ups from the Appellant's doctor. (Exhibit 2)

3. On [redacted], [redacted] conducted a telephone nursing assessment with the Appellant's caregiver, pursuant to a request to resume incontinent supplies. [redacted] notes indicate it was reported that the Appellant has mental retardation, congestive heart failure, and is incontinent of bladder overnight and sometimes during the day. Additional documentation indicated it was reported that the Appellant's medications did not include a diuretic. (Exhibit 1, pages 9-11)

4. [redacted] was unable to accept the [redacted] prescription as valid because it did not contain required information. The Department

also determined that the Appellant did not qualify for incontinence supplies because nighttime bed wetting is not covered and the Appellant does not have daytime incontinence on a daily basis. (Contract Manager Testimony)

5. On [redacted], the Department sent the Appellant an Adequate Action Notice that incontinent supplies would not be authorized because the information provided did not support coverage of this service. (Exhibit 1, page 8)

6. On [redacted], the Appellant's Request for Hearing was received. (Exhibit 1, page 6)

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 Department policy regarding medical necessity and prescription requirements is addressed in the MDCH Medicaid Provider Manual (MPM):

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.

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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.

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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.
>
> *MDCH Medicaid Provider Manual,*
> *Medical Supplier Section,*
> *January 1, 2012, Pages 4-7.*

The Department policy regarding coverage of incontinence products, including pull-on briefs, is also addressed in the MDCH Medicaid Provider Manual (MPM):

> **2.19 Incontinent Supplies**
> **Introduction**
>
> Incontinent supplies are items used to assist individuals with the inability to control excretory functions.
>
> The type of coverage for incontinent supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate:
>
> - Independent care of bodily functions through proper toilet training.
> - Appropriate self-catheter care to decrease risk of urinary infections and/or avoid bladder distention.
> - Proper techniques related to routine bowel evacuation.
>
> **Standards of Coverage (Applicable to All Programs)**
> **Diapers, incontinent pants, liners, and belted/unbelted undergarments without sides** are covered for individuals age three or older if both of the following applies:
>
> - A medical condition resulting in incontinence and there is no response to a bowel/bladder training program.

- The medical condition being treated results in incontinence, and beneficiary would not benefit from or has failed a bowel/bladder training program.

Pull-on briefs are covered for beneficiaries age 3 through 20 when there is the presence of a medical condition causing bowel/bladder incontinence, and one of the following applies:

- The beneficiary would not benefit from a bowel/bladder program but has the cognitive ability to independently care for his/her toileting needs, **or**
- The beneficiary is actively participating and demonstrating definitive progress in a bowel/bladder program.

Pull-on briefs are covered for beneficiaries age 21 and over when there is the presence of a medical condition causing bowel/bladder incontinence and the beneficiary is able to care for his/her toileting needs independently or with minimal assistance from a caregiver.

Pull-on briefs are considered a short-term transitional product that requires a reassessment every six months. The assessment must detail definitive progress being made in the bowel/bladder training. Pull-on briefs covered as a long-term item require a reassessment once a year or less frequently as determined by MDCH.

Documentation of the reassessment must be kept in the beneficiary's file.

Incontinent wipes are covered when necessary to maintain cleanliness outside of the home.

Disposable underpads are covered for beneficiaries of all ages with a medical condition resulting in incontinence.

Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries)

Intermittent catheters are covered when catheterization is required due to severe bladder dysfunction. **Hydrophilic-coated intermittent catheters** are considered for

individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras.

Intermittent catheters with insertion supplies are covered for beneficiaries who have a chronic urinary dysfunction for which sterile technique is clinically required.

Documentation

Documentation must be less than 30 days old and include the following:

- Diagnosis of condition causing incontinence (primary and secondary diagnosis).
- Item to be dispensed.
- Duration of need.
- Quantity of item and anticipated frequency the item requires replacement.
- For pull-on briefs, a six-month reassessment is required.

MDCH Medicaid Provider Manual,
Medical Supplier Section,
January 1, 2012, Pages 41-42.

On [redacted], [redacted] received a prescription for pull-ups from the Appellant's doctor. (Exhibit 2) On [redacted], [redacted] conducted a telephone nursing assessment with the Appellant's caregiver, pursuant to a request to resume incontinent supplies. [redacted] notes indicate it was reported that the Appellant has mental retardation, congestive heart failure, and is incontinent of bladder overnight and sometimes during the day. Additional documentation indicated it was reported that the Appellant's medications did not include a diuretic. (Exhibit 1, pages 9-11)

The Contract Manger explained that [redacted] was not able to consider the prescription valid because it was almost illegible and did not contain required information such as the Medicaid ID number, both primary and secondary diagnoses, and if refills would be available. The above cited Medicaid Provider Manual sections set out the general prescription and documentation requirements as well as specific requirements for incontinence supplies. The [redacted] prescription for pull-ups is not very legible, but appears to be missing several required items, including the Appellant's date of birth, either the Appellant's Medicaid ID number or Social Security number, both primary and secondary diagnoses, duration of need, quantity and frequency information, and if refills are available. Further, it appears there is only a diagnosis of incontinence, specifically urinary incontinence refractory to pharmacological treatment, but no primary or secondary diagnoses of condition(s) causing incontinence. (Exhibit 2)

The Contract Manager testified that the Department also determined the Appellant did not qualify for incontinent supplies because nighttime bed wetting is not covered and the Appellant does not have daytime incontinence on a daily basis. The standards of coverage for incontinent supplies do not state that incontinence must occur during the daytime on a daily basis. The standards of coverage do require a medical condition resulting in incontinence. As noted above, the doctor indicated a diagnosis of insentience itself on the prescription, but did not indicate what condition(s) cause the incontinence. The hearing request indicates that the Appellant is on a diuretic, Lasix. (Exhibit 1, page 7) Diagnoses of mental retardation, congestive heart failure, and sleep apnea were reported during the telephone nursing assessment on [redacted], but it does not appear that use of a diuretic was reported to [redacted]. (Exhibit 1, pages 9-11) However, neither the Appellant's diagnoses that result in incontinence nor any use of a diuretic were documented on the prescription from the Appellant's doctor.

The Department's denial must be upheld based on the information that was provided in [redacted]. The prescription cannot be considered valid because it is missing required information, there was no documentation of a medical condition resulting in incontinence from the doctor, and the use of a diuretic was not reported during the telephone nursing assessment nor documented by the doctor. With no valid prescription and insufficient information to establish a medical condition that results in incontinence, the denial was in accordance with Department policy.

If she has not already done so, the Appellant should have her doctor submit a valid prescription and ensure that other relevant information, such as the use of any diuretics, is provided to [redacted] to support the Appellant's request for incontinent supplies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department's denial of coverage for incontinent supplies based on the available information was in accordance with Department policy.

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 __5/11/2012_____

***** 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.