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) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2012-69906PA
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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented herself. [redacted], Appeals and Review Officer, represented the Department. [redacted], R.N. and Medicaid Utilization Analyst for the Department of Community Health was a witness on behalf of the Department.

ISSUE

Did the Department properly deny the Appellant's prior-authorization request for a standard hospital bed?

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 a [redacted]-year-old Medicaid beneficiary, who suffers from COPD, PVD, morbid obesity, severe sleep apnea and Back Pain. She has suffered a stroke and has residual left sided weakness.

2. The Department of Community Health has received multiple requests for continued coverage of the semi-electric hospital bed from [redacted] on behalf of the Appellant. (Appellant Exhibit A and Department Exhibit A).

3. On [redacted] the Department of Community Health sent a letter to medical supplier [redacted] requesting additional information and specifying physician documentation addressing the medical need for a hospital bed must be addressed including transfer or functional status that requires the hospital bed and why as well as economic alternatives ruled out and why failed. (Department Exhibit A, page 5)

4. In [redacted] the Appellant's doctor signed an explanation of need for the hospital bed and answered questions posed on the document, which was thereafter submitted to the Department by [redacted].

5. On [redacted] the Department of community Health denied the request for coverage of the hospital bed explaining in the denial notice that the requested information was not submitted "in full" Specifically, the notice states that "physician documentation clarifying transfer/functional status as well as how a hospital bed will alleviate pain and economic alternatives tried were not addressed". (Department exhibit A)

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 hospital beds can be found in the Medical Supplier section of the Medicaid Provider Manual:

> **2.18 HOSPITAL BEDS**
>
> **Definition** A hospital bed has a special construction, consisting of a frame and an innerspring mattress, with a head and/or leg elevation adjustment mechanism for the purpose of repositioning.
>
> **Standards of Coverage**
>
> A standard hospital bed may be covered if:
>
> - The diagnosis/medical condition requires a specific elevation or positioning of the body not possible with a standard bed (elevation of 30 degrees or greater).
>
> - The body requires positioning in a hospital bed to alleviate pain.
>
> For other beds, the above Standards of Coverage must be met, and one of the following applies:

- **Variable height hospital bed** may be covered if different heights are medically necessary for assisting beneficiary transfers from the chair, wheelchair or standing position.

- **Heavy-duty extra-wide hospital bed** may be covered if a beneficiary weighs more than 350 pounds but does not exceed 600 pounds.

- **Extra heavy-duty bed** may be covered if a beneficiary weighs more than 600 pounds.

- A **fully electric hospital bed** may be covered when frequent and/or immediate changes in body position are required and there is no caregiver.

- A **Youth bed** may be covered if the beneficiary is under the age of 21 and the bed is required to have crib style side rails.

Hospital Bed Accessories

- The **trapeze bar** may be covered when required by the beneficiary to assist with transfers or frequent changes in body position.

- **Side rails** are covered when required for safety.

- A **replacement innerspring** mattress or foam rubber mattress may be covered for replacement when the beneficiary owns the bed.

Noncovered Condition

Youth beds are not covered for the sole purpose of age appropriateness.

Documentation

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

- Diagnosis/medical condition related to the service requested.

- Medical and/or functional reasons for the specific type of hospital bed and/or accessory.

- Any alternatives tried or ruled out.

PA Requirements

PA is not required if the Standards of Coverage are met and the following applies:

- For fixed height, variable height, semi-electric beds, side rail, and trapeze for one of the following diagnoses/medical conditions:
    - Multiple Sclerosis
    - Infantile Cerebral Palsy
    - Congenital or Hereditary Progressive Muscular Dystrophy
    - Fracture of the Cervical or Dorsal Areas (open or closed)
    - Procedure codes E0255, E0256, E0260, E0292, E0293, E0910, E0940 up to three months for hospital discharge when required for diagnoses not removed from PA.

PA is required for:

- Medical need beyond the Standards of Coverage.
- Full electric beds or any other hospital beds and/or accessories requiring PA as specified in the MDCH Medical Supplier Database.
- Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within eight years.

Payment Rules

A bed 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 except for trapezes, side rails, and mattresses where appropriate.

- Education on the proper use and care of the equipment.

- Routine servicing and all necessary repairs or replacements to make the unit functional.

MDCH Medicaid Provider Manual,
Medical Supplier Section 2.18,
October 1, 2010, pages 40-41
(Exhibit 1, pages 15-16)

The Appellant was being discharged from rehabilitation and sought coverage of a semi electric hospital bed for use in her home. Her physician wrote her a prescription for the bed. She submitted it to the medical supplier who thereafter submitted the request to the Department of Community Health. The Department sought more information than initially provided, thus sent a letter to the medical supplier requesting it. The Medical supplier submitted a physician signed document addressing the questions posed by the Department in its March letter requesting additional information. Specifically, the document states:

> Explain medical condition appropriate for the hospital bed
> The answer provided is "copd, PVD, Alleviate pain"
>
> Explain reasons for the specific type of hospital bed and/or accessory
> The answer provided is "post cva with residual left sided weakness"
>
> What is the weight of the patient?
> The answer provided is "278"
>
> List ALL alternatives tried or ruled out AND explain in detail
> The answer provided is "need bed supportive to wt & needs"
>
> Explain why this patient requires a specific elevation or position of the body that is not possible with a standard bed
> The answer provided is "her PVD, (severe) sleep apnea chronic back pain"

The Department reviewed the answers and denied the requested bed asserting that the information sought had not been provided in full. The omitted information failed to address her transfer/functional status as well as how a hospital bed will alleviate pain and economic alternatives had not been addressed. This ALJ reviewed the submitted documentation as well as the Medicaid Provider Manual standards of coverage for hospital beds. The manual reads "medical and/or functional reasons for the specific type of hospital bed and/or accessory" It appears as if this documentation requirement was sought to be addressed by the Medical Supply Company when it sent questions to the prescribing physician asking him to answer. The questions asked included "explain the medical condition appropriate for the hospital bed and to explain the reasons for the specific bed". The answers provided address the medical reasons and functional status without using the term transfer/functional status. The answer includes the information that the Appellant is post CVA with residual left sided weakness. This addresses her transfer/functional status. The sentence structure of the answer did not include the exact phrase as posed by the Department; however, it does address the Appellant's

medical transfer/functional status and is at least as clear as the Medicaid Provider Manual documentation requirements themselves.

The doctor was asked to provide an explanation addressing why the Appellant has a need to achieve a specific body position she cannot achieve in a regular bed. The doctor did so in his answer, provided above. The doctor is asked to explain what alternatives were tried and ruled out. The answer provided rules out of use of a standard bed by indicating the Appellant needs a bed that will meet her needs and support her weight. The answer is not in list form. Again, this criticism by the Department is form over substance as a reasonable reading of the answers in their totality provides medical diagnosis, information about the Appellant's functional status, rules out use of a regular bed as an economic alternative and is current. After reading the documentation submitted this ALJ is able to ascertain the Appellant has severe sleep apnea, COPD, PVD, is obese, has suffered a stroke leaving residual left sided weakness and has back pain. Contrary to the Department's assertions, this information does address the standards of coverage listed in the Medicaid provider Manual and the documentation requirement included therein.

Finally, at hearing it was learned the Department witness had not been the decision maker for this particular determination. She stated she had not made the determination. Additionally, she further testified the indication of the Appellant's body mass index of 46.5 was a diagnosis code, not a BMI. She indicated she must have a "picture painted". There is no indication in the Medicaid provider manual that the documentation submitted must establish a picture of the person seeking coverage. This ALJ can attempt to give reasonable meaning to what the Department witness is expressing; however, reasonable meaning and interpretation must also be afforded the prescribing doctor's statements. Here, the Department did not give reasonable meaning and impact to the prescribing physician's explanations. When this ALJ gives reasonable meaning to the words used by the prescribing doctor, sufficient and full information is found adequate to find all requirements for coverage are met.

After review of the all the evidence of record this ALJ finds the documentation submitted was sufficient to establish medical necesity for the hospital bed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly denied the Appellant's request for a semi electric hospital bed.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

|S|
Jennifer Isiogu
Administrative Law Judge
for James Haveman, Director,
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/5/2013

***** 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.