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:

Docket No. 2013-31804 QHP

[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 on [redacted]. The Appellant appeared and testified on his own behalf. [redacted] Appeals Coordinator, represented the Medicaid Health Plan (MHP), [redacted], Medical Director appeared as a witness for the MPH.

ISSUE

Did the MHP properly deny the Appellant's request for a replacement CPAP Machine?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a [redacted]-year-old ([redacted]) Medicaid beneficiary. (Exhibit A, pp. 5, 6).

2. On or about [redacted] the MHP received a Prior Authorization Request from [redacted] and [redacted] on behalf of the Appellant for replacement Durable Medical Equipment (DME), i.e., a CPAP machine. (Exhibit A, pp. 5-7).

3. The Appellant was denied service for repair of his CPAP unit from [redacted] and [redacted] because his unit – S8 AutoSet II was damaged beyond repair due to heavy tobacco damage to all internal components. (Exhibit A, p. 7).

[redacted]

4. On [redacted] the MHP advised Appellant and the supplier that the request for a replacement CPAP was denied because the MPH is not responsible for replacing an item of DME damaged as the result of misuse or abuse by the beneficiary or the caregiver. Appellant's appeal rights were contained in the denial letter. (Exhibit A, pp. 8-11).

5. On [redacted] the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit 1).

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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified MHPs.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

[redacted]

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)

[redacted]

- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21 [Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22].

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures

[redacted]

> to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *Supra,* p. 49].

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The *Medicaid Provider Manual*, *Medical Supplier*, §1.8.C. Repairs and Replacement Parts, April 1, 2013, pp. 14-16 states in part:

> 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. 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.

* * *

[redacted]r

> Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. The RB modifier is required.
>
> For a repair in which no specific HCPCS code is appropriate, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. The RB modifier is reported for the replacement part of the DME furnished as part of the repair. PA is required. The provider must provide a manufacturer's invoice that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.
>
> The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDCH will consider replacement if the existing equipment meets coverage criteria or was purchased by the program.
>
> * * *
>
> MDCH will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form. [Emphasis added].

At hearing there was no dispute that the Appellant needed an operable CPAP machine. According to the Respondent's witness [redacted] the information they received informed them that the Appellant's device was damaged beyond repair due to heavy tobacco damage to all internal components. [redacted] stated he had never seen a CPAP damaged beyond repair before due to tobacco smoke, but he had seen some damaged by smoking marijuana through the nebulizer.

[redacted] referenced the policy quoted above from the Medicaid Provider manual and stated according to policy they could not replace DME due to damage to the item as a result of misuse or abuse by the beneficiary.

The Appellant testified that he does not smoke and does not have a wood burning stove so he does not understand how the CPAP could have been smoke damaged. Appellant indicated that [redacted] and [redacted] had six or seven units just like his when he brought it in for repair, but did not present any evidence to show that the company may have mixed up his unit with another one. He stated he has had good luck with [redacted] and [redacted] and doesn't believe they returned the wrong unit to him.

The Appellant has failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied him a replacement CPAP machine.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for a replacement CPAP machine was proper.

IT IS THEREFORE ORDERED that:

The MHP's decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

cc: [redacted]

[redacted]

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.