

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. 2013-44579 PA

██████████

██████████

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 ██████████. ██████████ wife, represented the Appellant. ██████████, Appeals Review Officer, represented the Department. ██████████, RN, Medicaid Utilization Analyst, appeared as a witness for the Department.

ISSUE

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

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 Medicaid beneficiary.
2. On ██████████ the Department received a prior authorization request from the medical supplier for a hospital bed for the Appellant. The submitted documentation was signed by a physician's assistant. (Exhibit 1 pages 15-18)
3. On ██████████, the Department denied the prior authorization request because medical documentation must be signed by the physician and because required documentation that economic alternatives have been tried and ruled out was not submitted. (Exhibit 1, pages 13-14)

4. On ██████████, the Michigan Administrative Hearing System received the Appellant's hearing request. (Exhibit 1, pages 4-7)

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 Michigan Department of Community Health (MDCH) Medicaid Provider Manual states:

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:

- The service/device meets applicable federal and state laws, rules, regulations, and MDCH promulgated policies.

- It is medically appropriate and necessary to treat a specific medical diagnosis, 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.
- The function of the service/device:
 - meets accepted medical standards;
 - practices guidelines related to type, frequency, and duration of treatment; and
 - is within scope of current medical practice.
- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device 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.
- The service/device 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.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

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.

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.

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/DME/Prosthetics and Orthotics Database.
- Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within five 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
January 1, 2013, pages 40-42

On ██████████, the Department received a prior authorization request from the medical supplier for hospital bed for the Appellant. The submitted documentation was signed by a physician's assistant. (Exhibit 1 pages 15-18) On ██████████ the Department denied the prior authorization request because medical documentation must be signed by the physician and because required documentation that economic alternatives have been tried and ruled out was not submitted. (Exhibit 1, pages 13-14)

The Appellant's wife acknowledged that the submitted medical documentation was signed by the Physician's Assistant rather than the physician. The Appellant's wife explained the problems with the Appellant's current hospital bed, which is about 15 years old, and why it needs to be replaced. The Appellant's wife also provided testimony regarding economic alternatives they have tried, such as using two wedges. However, they have not been able to get the Appellant to the needed 45 degree angle. (Wife Testimony)

The above cited policy is clear and consistent that a physician must sign all medical documentation. It is uncontested that in this case the medical documentation was signed by the physician's assistant. Further, the above cited policy also clearly and consistently requires documentation that economic alternatives have been ruled out. The medical documentation submitted with the ██████████ prior authorization request did not document that economic alternatives have been tried and ruled out. (Exhibit 1, pages 15-18) Accordingly, the Department's denial of the ██████████ prior authorization request must be upheld.

If he has not already done so, the Appellant can have a new prior authorization request for a hospital bed submitted to the Department with the physician's signature on all medical documentation and include documentation that economic alternatives have been tried and ruled out.

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 Appellant's request for a hospital bed based on the available information.

IT IS THEREFORE ORDERED that:

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

Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [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 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.