

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

████████████████████

Appellant

_____ /

Docket No. 2013-67887 QHP

Case No. ██████████

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 ██████████. Appellant was represented by ██████████, Guardian. Witnesses on behalf of Appellant included ██████████, CMH Support Coordinator, and ██████████, Occupational Therapist, CMH. The Medicaid Health Plan (MHP), ██████████, (MHP) was represented by ██████████, Attorney at Law. Witnesses on behalf of the MHP included Dr. ██████████ and ██████████.

ISSUE

Did the MHP properly deny the Appellant's request for a repairs to a Pedicraft enclosed safety bed?

FINDINGS OF FACT

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

1. Appellant is a ██████-year-old male Medicaid beneficiary, born ██████████, who is an SSI recipient.
2. Appellant was born with severe disabilities from autism, CP, grand mall seizures, and is developmental disabled. Appellant requires 24 hour supervision for safety.
3. Appellant has grand mal seizures that have been progressively increasing in ██████. Appellant has been hospitalized overnight on several occasions due to seizures.

4. Appellant uses a Pediacraft net enclosed safety bed nightly, that stops Appellant from wandering, risk of injury and falls, and from leaving the house during the night.
5. Appellant's enclosed bed system needs repair as the zipper is wearing out and there are several rips and holes in the netting of the canopy.
6. On or about ██████████, Appellant's physician filled a 'medical necessity' letter with the MHP indicated that Appellant needs repair of the equipment to prevent Appellant from falling out of bed and hurting himself and that it was medically necessary for Appellant's safety.
7. On ██████████ the MHP denied Appellant's request.
8. On ██████████, Appellant filed a hearing request.
9. On ██████████, the MHP reviewed Appellant's request and affirmed a previous denial for repair on the grounds that there is no documentation to show that that less costly methods have been tried such as a floor level mattress with fall mats or child protection devices such as gates, door knob covers, and/or bed or door alarm.

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 MHP signs a contract with the State of Michigan identifying certain services that are required. The applicable contract to the facts herein states in part:

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:

- 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

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- 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/EPSTD 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 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].

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services. An MHP must also provide its members with the same or similar services or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual.

In this case, the facts herein fall under the “2.12 Enclosed Bed Systems” item. This item states:

SECTION 12 – Enclosed Bed Systems

...Standards of Coverage

An Enclosed Bed System may be covered if the following applies:

- *There is a diagnosis/medical condition (e.g. seizure activity) which could result in injury in a standard bed, crib, or hospital bed; and
- *There are no economic alternatives to adequately meet the beneficiary’s needs.

Documentation: ...

- *Diagnosis/medical condition requiring use of the bed and any special features (if applicable).
- *Safety issues resulting from the medical condition and related to the need for an Enclosed Bed System.
- *Other products or safety methods already tried without success (e.g., bumper pads/rails).

...

Noncovered Conditions:

Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc....

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Medicaid Provider Manual; Practitioner
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In this case, the MHP argued that documentation is insufficient to show that Appellant has tried alternative economically feasible options, such as a mattress on the floor or child protection devices in Appellant's room. The MHP's physician also raised some concern regarding the safety of the bed system and that the system should not be used for restraint.

Appellant argued that alternatives have been tried, as evidenced by bed rails used by the hospital when Appellant was hospitalized with seizures-Appellant climbed over them. Appellant also tried to sleep in the bed without the zipped feature and this was unsuccessful.

The undersigned administrative law judge (ALJ) has reviewed the credible and substantial evidence on the whole records and finds that the MHP has sufficiently demonstrated that Appellant did not establish that he has verified that he met the requirements established under Section 12. Specifically, Appellant has not shown that other economically feasible alternatives have been utilized, such as placing a mattress on the floor, and/or the child safety devices such as an alarm, as suggested by the MHP. Thus, this ALJ affirms the denial.

In reaching this conclusion, this ALJ wishes to note that two evidentiary facts play a significant role as to weight. First, Appellant's guardian has already argued that Appellant is in need of 24-7 supervision. Thus, an alarm on the door is not unreasonable. Second, the concerns raised by the MHP regarding dangerousness is sufficient to require Appellant to meet bring forth sufficient evidence to fully meet the documentation requirements found in the Medicaid Provider Manual cited above in Section 2.12.

The purview of an Administrative Law Judge (ALJ) at an administrative hearing is to review the action taken, and, to make a determination if that action is correct under the parameters of the Plan (and not contrary to the Medicaid Policy and/or law). As the verification submitted by Appellant does not show that alternative, economically feasible alternatives identified in the Medicaid Provider Manual have been met, this ALJ must uphold the denial under these facts. Appellant understands that he may reapply.

[REDACTED]
Docket No. 2013-67887 QHP
Decision and Order

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 repair of an Enclosed Bed System was correct.

IT IS THEREFORE ORDERED that:

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

/s/

Janice Spodarek
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]
[REDACTED]

Date Signed: December 19, 2013

Date Mailed: December 19, 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 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.