**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

**IN THE MATTER OF**:

**Docket No.** 14-008260 HMS

[redacted] [redacted] [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.*, and upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], [redacted], Appellant's Authorized Hearing Representative, appeared and testified on Appellant's behalf. [redacted] paralegal, represented [redacted], the Respondent Medicaid Health Plan (MHP). [redacted], the MHP's Medical Director, testified as witness for Respondent.

## ISSUE

Did the MHP properly deny Appellant's request for a home ultraviolet light therapy unit?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old male who has been diagnosed with eczema and psoriasis, and who is enrolled with the Respondent MHP. (Respondent's Exhibit A, pages 13-14).

2. In being treated for his conditions, Appellant may receive ultraviolet light therapy at his doctor's office up to [redacted] times a week. (Testimony of Appellant's representative).

3. On [redacted], the MHP received a prior authorization request submitted on behalf of Appellant and requesting a home ultraviolet light therapy unit. (Respondent's Exhibit A, pages 13-24).

4. With respect to the reason for requesting a home unit, the prior authorization included a form with boxes checked next to "Therapy is Considered Long-Term" and "Distance and Travel to Office". (Respondent's Exhibit A, page 16).

5. The request also identified a Healthcare Common Procedure Coding System (HCPCS) number for the requested item: E0694 (Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection). (Respondent's Exhibit A, pages 13-14).

6. In reviewing that request and applying the HCPCS number to the Medical Supplier/Durable Medical Equipment (DME)/Prosthetics and Orthotics Database used by the Michigan Department of Community Health (MDCH), the MHP determined that the requested device was not listed and not covered. (Testimony of [redacted]

7. On [redacted], the MHP sent Appellant written notice that the request for a home ultraviolet light unit was denied on the basis that the device was not covered under Michigan contract rules. (Respondent's Exhibit A, page 3).

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, pages 1-3).

## 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.

In 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 Medicaid Health Plans.

The Respondent is one of those MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to

> Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.
>
> *Medicaid Provider Manual, July 1, 2014 version*
> *Medicaid Health Plan Chapter, page 1*
> *(Emphasis added by ALJ)*

As stated above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." Here, the pertinent section of the applicable version of the MPM) states:

> **1.2 MDCH MEDICAL SUPPLIER/DME/PROSTHETICS AND ORTHOTICS DATABASE**
>
> For specifics regarding the Healthcare Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website. (Refer to the Directory Appendix for website information.) The database includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, ICD diagnosis codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes

the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

### 1.2.A. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement, as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by HCPCS level I or Current Procedural Terminology (CPT) codes.

HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service. Decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment.

National permanent codes are maintained by the Centers for Medicare & Medicaid Services (CMS) HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. The permanent national codes serve the function of providing a standardized coding system that is managed jointly by private and public insurers.

National codes also include miscellaneous/not otherwise classified (NOC) codes. These codes are used when a medical supplier submits a bill or request for an item or service where there is no existing national code that adequately describes the item or service. Before using a miscellaneous/NOC code, the

medical supplier should check with the Medicare Pricing, Data Analysis and Coding (PDAC) contractor to determine whether there is a specific code that should be used. (Refer to the Directory Appendix for contact and website information.)

When submitting a bill or request, medical suppliers are required to use HCPCS codes to identify items. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. MDCH reserves the right to determine and apply correct HCPCS codes used for the purpose of reimbursement.

* * *

**1.5 MEDICAL NECESSITY [CHANGE MADE 4/1/14]**

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.

MDCH does not cover the service when Medicare determines that the service is not medically necessary.
**(text added 4/1/14)**

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.

*MPM, July 1, 2014 version*
*Medical Supplier Chapter, pages 2-6*

Here, Respondent's Medical Director testified that Appellant's prior authorization request was denied pursuant to the above policies. Specifically, he noted that the MHP reviewed the request and checked the Department's database for the HCPCS number of the requested equipment, only to find that the equipment was not listed or covered.

In response, Appellant's representative testified that it would be cheaper in the long run for the MHP to simply buy Appellant a home unit that to pay for multiple treatments at the doctor's office per week. She also testified that it is embarrassing for Appellant to go out in public due to his medical conditions and it is very inconvenient to make multiple trips to the doctor's office per week.

Appellant and his representative bear the burden of proving by a preponderance of the evidence that the MHP erred in denying his prior authorization request. Moreover, this Administrative Law Judge's jurisdiction is limited to reviewing the MHP's decision in light of the information it had at the time it made that decision.

In this case, the undersigned Administrative Law Judge finds that Appellant and his representative have failed to meet their burden of proving that the MHP erred. While the HCPCS is not a system for making coverage or payment determinations, it is significant that the requested equipment is not listed among covered items in the database. Moreover, there was simply no evidence or information submitted along with the prior authorization request regarding the medical necessity of the requested equipment. Any embarrassment or

inconvenience Appellant has from making multiple trips to the doctor does not equal medical necessity. Similarly, while Appellant's representative asserts that a home unit would be the most cost-effective treatment available, her testimony is merely speculative and the documentation submitted to the MHP did not identify cost to the MHP or the Department as a basis for the request or provide any evidence that would support Appellant's representative's testimony.

Accordingly, given what was submitted along with the requests and the lack of evidence regarding medical necessity, Appellant and his representative have failed to meet their burden of proof and the MHP's decision must be sustained.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for a home ultraviolet light therapy unit.

**IT IS THEREFORE ORDERED** that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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 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.