

**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. 2014-12754 QHP

██████████

██████████

██████████

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 the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████ Appellant's caregiver, appeared and testified on her behalf. Appellant and ██████████, Appellant's son, also testified on Appellant's behalf. ██████████ Appeals Coordinator, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████, a Medical Director at the MHP, testified as a witness for Respondent.

ISSUE

Did the MHP properly deny Appellant's request for a transfer bench and bath tub wall rail?

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 ██████ year-old Medicaid beneficiary enrolled in the Respondent MHP. (Respondent's Exhibit A, pages 11, 14; Testimony of Appellant's representative).
2. On ██████████ and ██████████, ██████████ prescribed a bathroom hand rail, shower rails, and a shower chair for Appellant. (Respondent's Exhibit A, pages 9-10).
3. On or about ██████████, the MHP received a prior authorization requests submitted on behalf of Appellant by her doctor and ██████████, a provider of home medical equipment, prosthetics, orthotics, respiratory services, and medical supplies. (Testimony of ██████████).

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4. The request contained the two prescriptions from [REDACTED]. (Testimony of [REDACTED]).
5. The request also identified two Healthcare Common Procedure Coding System (HCPCS) numbers for the requested equipment: E0241 (Bath Tub Wall Rail) and E0248 (Transfer Bench, Heavy Duty, For Tub or Toilet, With or Without Commode Opening). (Respondent's Exhibit A, page 17; Testimony of [REDACTED]).
6. Applying those codes to the Michigan Department of Community Health's Medical Supplier [REDACTED], the MHP discovered that that the requested equipment is only covered for the ages [REDACTED]. (Respondent's Exhibit A, page 17; Testimony of [REDACTED]).
7. Accordingly, the MHP decided that the prior authorization requests must be denied. (Testimony of [REDACTED]).
8. On [REDACTED], the MHP sent both Appellant and [REDACTED] written notice that the requests for a tub bench and wall rail were being denied as they were not covered benefits in this case. (Respondent's Exhibit A, pages 15-20).
9. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, pages 1-15).

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

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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, October 1, 2013 version
Medicaid Health Plan Chapter, page 1
(Emphasis added by ALJ)*

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.” Here, the pertinent sections of the applicable version of the Michigan Medicaid Provider Manual (MPM) state:

**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

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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.

* * *

1.4 AGE LIMITATIONS

Coverage may be different based on the beneficiary's age. For specifics of HCPCS codes and age parameters, refer to the Coverage Conditions and Requirements Section of this chapter and the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website.

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

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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.

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- 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, October 1, 2013 version
Medical Supplier Chapter, pages 2-6*

While either the process outlined in the above policy or the MHP's own prior authorization requirements should clear up any initial questions regarding what is being requested, there appears to be some confusion on that issue in this case. For example, while Appellant testified that she only wants a shower chair and shower rails, her doctor also prescribed her a bathroom hand rail and the case codes used by ██████████ in the actual request refer to a bath tub wall rail and a Transfer Bench for a tub or toilet,.

Regardless of that confusion, 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 and, in this case, the required case codes provided in the request identify what equipment or supplies are at issue.

Moreover, given the case codes used in this case, the MHP properly denied Appellant's prior authorization requests. While the HCPCS is not a system for making coverage or payment determinations, the MPM specifically states that coverage may differ based on a beneficiary's age and that a supplier must refer to both HCPCS codes/age parameters and the MDCH Medical Supplier ██████████ in approving equipment and supplies. Here, as provided in the database, the age parameters for the requested equipment are only ██████. Appellant is ██████ years-old and therefore falls outside of the age parameters.

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To the extent a mistake was made with respect to the case codes used or Appellant has new or updated information to provide, she is free to submit another prior authorization request at any time. The denials at issue in this case, however, must be sustained given the information submitted to the MHP in support of the requests.

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 requests for a transfer bench and a bath tub wall rail.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.



Steven Kibit
Administrative Law Judge
for James K. Haveman, 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.