STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax: (517) 373-4147

IN THE MATTER OF:

MAHS Docket No. 15-021196 MHP

[redacted],

Appellant

[redacted]/

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 hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Director of Customer Service, appeared and testified on behalf of [redacted] the Respondent Medicaid Health Plan (MHP). [redacted], Medical Director, also testified as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's prior authorization request to extend approval of a continuous positive airway pressure (CPAP) device?

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 Medicaid beneficiary who is enrolled in the Respondent MHP and who has been diagnosed with obstructive sleep apnea. (Exhibit A, pages 1, 4).

2. In [redacted], the MHP approved a request for a CPAP device for Appellant. (Undisputed testimony).

3. Subsequently, over a [redacted] night period, Appellant only used the CPAP device on [redacted] nights. (Exhibit A, page 4).

4. During [redacted] of the [redacted] nights she did use the CPAP, Appellant used the CPAP device for less than [redacted] hours. (Exhibit A, page 4).

5. On [redacted], Appellant's provider submitted a prior authorization request on Appellant's behalf to extend the approval of the CPAP device. (Exhibit A, pages 2-4).

6. On [redacted], the MHP sent Appellant written notice that the prior authorization request was denied. (Exhibit A, pages 8-10).

7. Regarding the reason for denial, the notice stated in part:

> The reasons for the denial are as follows:
>
> - Documentation does not indicate electronic monitoring usage of [redacted]) hours per night on [redacted] of available nights.
>
> The decision is based on benefit coverage, evidence-based medical guidelines, scientific facts, FDA regulations, medical necessity, and/or other criterion, as supported below:
>
> - The Medicaid Provider Manual, Section 2.10 Continuous Positive Airway Pressure Device, states that for continued coverage beyond the initial months, documentation must substantiate that the beneficiary has been compliant with the use of the of the CPAP and the device continues to be effective in treating the condition.
>
> Exhibit A, page 8

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, page 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 statutes, 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.
>
> *MPM, October 1, 2015 version*
> *Medicaid Health Plan Chapter, page*
> *(Emphasis added)*

Pursuant to the above policy and its contract with the Department, the MHP has developed prior authorization requirements and utilization management and review criteria. Specifically, it uses standards developed by the Centers for Medicare and Medicaid Services (CMS) and, with respect to continued coverage of CPAP devices,

that policy states in part that the treating physician must perform a clinical reevaluation that documents:

> Objective evidence of adherence to use (defined as use of PAP devices for 4 or more hours per night on 70% of nights during a consecutive 30-day period anytime during the first three months of initial use) of the PAP device, reviewed by treating physician.
>
> **NOTE:** Documentation of adherence to PAP therapy must be determined through direct download or visual inspection of usage data with written documentation provided in a report to be reviewed by the treating physician and included in the patient's medical record.

Exhibit A, page 15

The MHP's utilization review criteria also tracks the Department's policy found in the Medicaid Provider Manual (MPM):

> **2.10 CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE**

Definition	The continuous positive airway pressure (CPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts.
Standards of Coverage	A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ▪ Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or ▪ AHI documents 5 to 14

	events per hour with related symptoms such as: ➢ Excessive daytime sleepiness, impaired cognition, mood disorders; and/or ➢ Hypertension, ischemic heart disease, or history of stroke, or morbid obesity. For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition related to the need for the CPAP device. ▪ A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep.

	▪ For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted. ▪ Prescription from an appropriate pediatric subspecialist is required **for coverage under the CSHCS Program.**
PA Requirements	PA is not required if the Standards of Coverage are met and: ▪ The beneficiary is over the age of 21 and has one of the following diagnoses: ➢ Obstructive Sleep Apnea (Adults) ➢ Tracheostomy Complications ➢ Tracheomalacia ➢ Other Anomalies of Larynx, Trachea, and Bronchus ➢ Insomnia with Sleep Apnea ➢ Hypersomnia with

	Sleep Apnea ➢ Other and Unspecified Sleep Apnea ▪ For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea. ▪ The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years. PA is given for the initial four months and then for the final six months.
Payment Rules	A CPAP device is considered a capped rental item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the

	unit functional. After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPAP mask should be considered prior to replacement of the entire mask.)

MPM, October 1, 2015 version
Medical Supplier Chapter, pages 34-36

Pursuant to the above policies, the MHP denied Appellant's prior authorization request to extend approval of a CPAP device. Specifically, the notice of denial provided and the MHP's witness testified that CPAP devices are only approved after [redacted] months if there is objective evidence of adherence to use of the CPAP device, with adherence defined as use of CPAP devices for [redacted] or more hours per night on [redacted] of nights during any consecutive [redacted]-day period anytime during the first [redacted] months of initial use. The notice of denial and the MHP's witness also stated in this case that, given the usage data in this case, Appellant never used the CPAP device for [redacted] or more hours per night on [redacted] of nights during any consecutive [redacted]-day period and the request had to be denied.

In response, Appellant did not dispute the usage data relied upon by the MHP. Instead, she testified that she initially had trouble with the device and that, after it was replaced, she was sick and could not use it consistently.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying her request.

Given the record in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that the MHP's decision must therefore be affirmed. The MHP is permitted by Department policy and its contract to develop review criteria; it has done so; and, pursuant to the applicable review criteria, Appellant clearly does not meet the requirements for the continued approval of a CPAP device as it is undisputed that Appellant failed to be compliant with use of the device. Appellant's testimony and explanation for why she was non-compliant is understandable, but it is also unsupported by the request submitted to the MHP, which does not address the usage data, and it is insufficient given the clear policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the prior authorization request to extend approval of a CPAP device.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.