FRANCIS XAVIER SHUMSKY
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Date Mailed: May 21, 2020
MOAHR Docket No.: 20-001175
Agency No.: 1206518212
Petitioner: Francis Xavier Shumsky

ADMINISTRATIVE LAW JUDGE: Steven Kibit

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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on May 12, 2020. Attorney Jack Pivar appeared on Petitioner's behalf. Jennifer Shumsky, Petitioner's mother, testified as a witness for Petitioner. John Lambert, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). Mellody London, Review Analyst, and Dr. Eileen Donovan, Medical Consultant, testified as witnesses for the Department.

During the hearing, the Department submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-54. Petitioner's proposed exhibits were included as part of that packet.[1]

ISSUE

Did the Department properly deny Petitioner's prior authorization request for a specialty bed?

[1] At the onset of the hearing, the Department also moved for dismissal of the case on the basis that Petitioner's request for hearing was untimely. The undersigned Administrative Law Judge declined to make a ruling on the motion at that time and the hearing continued as scheduled. Upon review, the undersigned Administrative Law Judge now finds that, given the relevant dates and R 792.10104, regarding the computation of time, Petitioner's request for hearing was timely and the Department's motion must be denied.

FINDINGS OF FACT

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

1. Petitioner is an eighteen-year-old Medicaid beneficiary who has been diagnosed with Duchanne Muscular Dystrophy (DMD); decreased cardiac ejection fraction; obstructive sleep apnea (OSA); ankle contractures; and gastroesophageal disease with esophagitis. (Exhibit A, pages 40-41).

2. On November 7, 2019, the Department received a prior authorization request for a specialty bed submitted on Petitioner's behalf. (Exhibit A, pages 38-42).

3. Attached to that request, Petitioner's doctor wrote a letter stating in part that Petitioner is unable to ambulate, transfer or move in bed independently; he has impaired tone, joint contractures, fatigue and pain; and he needs assistance with all turns in bed. (Exhibit A, page 41).

4. Petitioner's doctor also wrote in part that:

> Due to his low muscle tone and weakness caused by his DMD, [Petitioner] needs assistance with all turns in bed. The Freedom Bed does not require manual caregiver assisted turning or repositioning. It is medically necessary that [Petitioner] has a Freedom Bed with the appropriate rails and mattress to prevent injury and falls from the bed with caregiver turns or position changes. The risk for falls could cause further complications or hospitalizations as patients with DMD have slower recovery times from injuries, such as fractures. [Petitioner] requires the high/lo function of the Freedom Bed so that he can sit on the side of the bed with his feet on the floor for stability for hygienic care, including his handheld urinal.
>
> Additionally, the Freedom Bed with an appropriate mattress will assist [Petitioner] with pressure injury prevention and relief from his compression fractures as it will allow him to adequately change his position safely in bed. He requires a mattress that does not envelope him during alternating pressure or when

> rotation is needed as he does not have the strength to get out of bed or disentangle himself.
>
> In addition to his OSA, [Petitioner] also has a history of pneumonia and he requires the functions of the Freedom Bed for positioning to maintain his airway at night. These features are only available with a Freedom Bed and include: Continuous Lateral Rotation Therapy, of up to 30 degrees with concurrent bed frame positioning of up to 20-degrees in Reverse Trendelenburg and 30-degree head elevation. Due to his mobility and strength issues, his bed should have adaptive control features, such as a push-button and/or sip and puff turning capability, which are features of the Freedom Bed.

Exhibit A, pages 41-42

5. On November 26, 2019, the Department sent Petitioner written notice that the prior authorization request had been denied. (Exhibit A, pages 6-7).

6. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Section 1.11 of the Medical Supplier chapter of the Medicaid Provider Manual. Specifically:
>
> - Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary would qualify for semi electric or full electric bed. 1.6 MEDICAL NECESSITY MDHHS does not cover the service when Medicare determines that the service is not medically necessary.
>
> - 1.11 NONCOVERED ITEMS Item's [sic] that are not covered by Medicaid include, but are not limited to. [sic] A fully electric hospital bed may be covered when frequent and/or immediate changes in body position are required and there is no caregiver. How

many hours does the beneficiary spend in bed daily? Does the beneficiary have a caregiver?

- Resubmit with documentation regarding caregiver status – how many hours per day are caregivers (skilled nursing, family members, etc.) providing direct care to the beneficiary (i.e. available to assist with transfers and positioning, bathing, etc.). The Physician must rule out the use of a semi-electric hospital bed and less costly alternatives from a medical standpoint.

Exhibit A, page 36-37

7. On February 24, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding that denial. (Exhibit A, pages 4-34).

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.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM) and, with respect to medical equipment and supplies, the applicable version of the MPM states in part:

1.6 MEDICAL NECESSITY [CHANGE MADE 10/1/19]

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. *DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need 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, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS **(added per bulletin MSA 19-10)** NP or PA. 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 MDHHS 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 MDHHS 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 safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.

- The function of the service/device:

  - meets accepted medical standards, practices and 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, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.*
- The service/device meets the standards of coverage published by MDHHS.
- 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.

MDHHS does not cover the service when Medicare determines that the service is not medically necessary.

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.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

MPM, October 1, 2019 version
Medical Supplier Chapter, pages 7-8
(Internal highlighting omitted)
(Italics added for emphasis)

Regarding hospital beds, the MPM also states:

2.17 HOSPITAL BEDS [RE-NUMBERED 10/1/19]

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 Medicaid Code and Rate Reference tool. ▪ 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.

MPM, October 1, 2019 version
Medical Supplier Chapter, pages 7-8

Here, the Department denied Petitioner's request for a specialty bed pursuant to the above policies.

In support of that decision, the Department's Review Analyst testified that Petitioner's prior authorization request was denied because less costly alternatives were not ruled out. She also testified that, as provided in the notice, Petitioner can always re-request the bed with additional information, and that, if he does so, he should include the information about how often Petitioner is in the bed; his caregiver situation; and what other alternatives have been tried or considered.

The Department's Medical Consultant further testified that, while the letter of medical necessity submitted along with the request asks for a specific type of bed and describes why it will meet Petitioner's needs, that letter is insufficient given that it does not discuss what Petitioner currently uses and why that bed no longer works or anything else tried and failed. According to the Medical Consultant, Petitioner cannot just say why the requested bed is appropriate and less costly alternatives, such as semi-electric and full-electric beds, need to be ruled out. She also testified that she does not know the lifespan of the requested bed or the less costly beds she identified.

In response, Petitioner's mother, who is also a registered nurse (RN) testified regarding what Petitioner is a currently using, *i.e.* a hospital bed with a regular mattress, and Petitioner's inability to turn or do anything else for himself in that bed. She also testified that she cannot turn or reposition Petitioner, and that, while Petitioner's father has been doing it, Petitioner's father has his own health problems. She further testified that, due to the COVID-19 pandemic, Petitioner has no other supports and he spends most of the day in bed. Petitioner's mother also testified that Petitioner needs to be turned during the night; he wants to do it himself; and electric beds or other proposed alternatives will not help him because they do not provide independent repositioning.

The Department's Review Analyst then testified that new beds are approved every five years, if otherwise covered, and that, with an appropriate mattress, a less-costly bed can meet Petitioner's needs.

The Department's Medical Consultant also testified that Petitioner needs to provide the additional information identified during the hearing in writing, especially given that he is requesting such a big jump from a regular bed to a very expensive specialty bed. She further testified that a pressure-relieving mattress could work to help turn Petitioner and that Petitioner cannot just say that a hospital bed and regular mattress are not working.

In his closing argument, Petitioner's representative argued in part that, given the long lifespan of the requested bed versus the short lifespan of the less-costly beds suggested by the Department, it will actually be less costly in the long run to the Department to approved the requested bed.

Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request. Moreover, the undersigned Administrative Law Judge is limited to reviewing Department's decision in light of the information available at the time the decision was made.

Given the record and applicable policy in this case, Petitioner has failed to meet his burden of proof and the Department's decision must be affirmed.

Petitioner's treating physician has requested the custom bed for Petitioner and broadly stated that it is medically necessary, but that request and general statement are not dispositive; the above policies also provide that medical equipment must be the least costly alternative that meets the beneficiary's medical/functional need; and Petitioner's request failed to demonstrate that the requested bed was the most cost-effective alternative available. In particular, the request and letter of medical of necessity written by Petitioner's doctor failed to describe Petitioner's current situation, including why it is no longer working for him, and any other less-costly alternatives that have either been tried and failed or considered and ruled out. The Department cannot simply assume that less-costly alternatives have been considered and rejected; and the Medical Consultant described specific, and less-costly alternatives that may meet Petitioner's needs and that need to be addressed as part of Petitioner's request. Moreover, while Petitioner's representative suggested that the requested bed will be cheaper in the long run, the record fails to support that speculation.

Petitioner's witness and evidence did supply some of the information sought by the Department during the hearing, but that information was not provided to the Department as part of the prior authorization request and the undersigned Administrative Law Judge is limited to reviewing Department's decision in light of the information available at the time the decision was made.

To the extent Petitioner has updated or additional information to provide, then he and his doctor can always submit a new prior authorization request with that information. With respect to the issue in this case however, the Department's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS, THEREFORE, ORDERED that:

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

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

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