GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
DIRECTOR

[redacted]
[redacted] MI [redacted]

Date Mailed: March 14, 2024
MOAHR Docket No.: 24-001398
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 a request for hearing filed by Petitioner.

After due notice, a telephone hearing was held on March 7, 2024. [redacted] Petitioner's mother, appeared and testified on the minor Petitioner's behalf. John Lambert, Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (DHHS or Department). Mellody London, Review Analyst, testified as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny Petitioner's prior authorization request for an enclosed bed system?

FINDINGS OF FACT

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

1. On January 23, 2024, the Department received from Petitioner, a request for an enclosed bed system. (Exhibit A, p 14, 17-22; Testimony.)

2. On January 30, 2024, the Department sent petitioner a Notification of Denial. The notice indicated the Petitioners request for an enclosed bed system was denied. The notice stated specifically:

> Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc. Section 2.12 of the Medical Supplier Chapter in the Medicaid Provider Manual.[1]

3. On February 14, 2024, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit A, p 8.)

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, in part, the applicable version of the MPM states:

> **1.6 MEDICAL NECESSITY**
>
> 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 NP or PA. Information in the medical record must support the item's

[1] Exhibit A, p 15.

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.

* * *

1.6.C. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic

PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.6.D. CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

A CMN must contain all of the following:

- Beneficiary's name and address;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number (if initiated by the provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements section and the Face-to-Face (F2F) Visit Requirements subsection of this chapter.

MDHHS will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist,

or prosthetist may not alter or write the medical reason or necessity for the item requested.

Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item.

* * *

2.12 ENCLOSED BED SYSTEMS

Definition	An Enclosed Bed System includes the mattress, bed frame, and enclosure as one unit.
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	The documentation must be less than six months old and include: ▪ 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). ▪ Type of bed requested. ▪ Type of special features requested, if applicable.
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.
PA Requirements	PA is required for all Enclosed Bed Systems.
Payment Rules	The Enclosed Bed System is considered a **purchase only** item. For Youth Beds, refer to the Hospital Beds subsection of this chapter.[2]

Here, the Department's witness testified that Petitioner's prior authorization request was denied pursuant to the above policies. The witness specifically noted that the medical documentation provided indicated a need for the bed to restrain the beneficiary due to behavioral issues.

Specifically, the witness testified that, as reflected in the submitted documentation, Petitioner's diagnoses were more behavioral than medical for this case and this kind of bed, with discussion of Petitioner's elopement risk and self-abusive behaviors. She also testified why those behavioral concerns do not satisfy the applicable policies and how there is nothing in the request related to potential injuries in standard beds as required.

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

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

The above policies expressly provide that enclosed bed systems are not covered when the purpose is to restrain a beneficiary due to behavioral conditions, caregiver need or convenience, and that appears to be the primary purpose of the request in this case. The letter of medical necessity, letter from Petitioner's doctor, and the office visit notes consistently highlight the need to prevent elopement, self-injurious behaviors, and impulsive behaviors, all of which relate to behavioral concerns and cannot meet the criteria for approval.

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.

[2] Medicaid Provider Manual, Medical Supplier Chapter, pp 9-10, 12-13, 46-47.

IT IS, THEREFORE, ORDERED that:

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

CA/pe

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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

Via Electronic Mail:

Petitioner
[redacted]
[redacted] MI [redacted]
[redacted]

Authorized Hearing Representative
[redacted]
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