STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVE.
HARTFORD, CT 06105-3725

[redacted] 2018
Signature Confirmation

Client ID # [redacted]
Request # 123711

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Community Health Network of Connecticut ((“CHNCT”) sent [redacted] (the “Appellant”) a Notice of Action (“NOA”) denying a request for authorization for the rental of a continuous passive motion exercise (“CPM”) machine.

On [redacted] 2018, the Appellant requested an administrative hearing to contest CHNCT decision to deny the authorization request for the CPM machine.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted] Appellant
[redacted], Appellant’s Mother
Rosa Maurizio, CHNCT Representative
Barbara McCoid, CHNCT Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether CHNCT's denial of the authorization request through the Medicaid program for a continuous passive motion ("CPM") machine as not medically necessary, was in accordance with state law.

FINDINGS OF FACT

1. The Appellant is a participant in the Medicaid program as administered by the Department of Social Services (the "Department"). (Hearing Record)

2. CHNCT is the Department's contractor for reviewing medical requests for authorization of durable medical equipment ("DME"). (Hearing Record)

3. The Appellant is age [redacted] born on [redacted]. (Exhibit 1: Prior Authorization and Appellant's Testimony)

4. [redacted] ("surgeon"), [redacted] (the "hospital") is the Appellant's surgeon. (Exhibit 1: Prior Authorization, Exhibit 7: Clinical Information and Appellant's Testimony)

5. The Appellant has a diagnosis of [redacted]. (Hearing Record)

6. On [redacted] 2018, the hospital admitted the Appellant where she underwent left hip surgery that involved manipulation of the soft tissues surrounding the hip joint and bony work to re-model the joint to provide pain relief and improve the range of motion. (Appellant's Testimony and Exhibit 7: Clinical Information)

7. On [redacted] 2018, the hospital discharged the Appellant home. (Appellant's Testimony)

8. The Appellant's discharge plan included blood thinner medication to be taken for four weeks to decrease the risk of a blood clot, physical therapy beginning two weeks after surgery for two to three times per week, and use of a CPM machine for 21 days, 8 hours per day necessary to prevent blood clots and prevent the hip from locking up. The Appellant's mother and sister were diagnosed with [redacted] resulting in an increased risk of blood clots. (Appellant's Testimony and Mother's Testimony)

9. A CPM machine is a device used by patients after surgery to discourage adhesions around the capsule of the hip by elevating the patient's leg and

moving the leg continuously to prevent stiffness and locking of the joints. (Appellant's Testimony and Exhibit 7: Clinical Information)

10. A CPM machine is not standard treatment for patients having hip surgery. A CPM machine is standard treatment for knee replacement surgery. (Hearing Record)

11. [redacted] (the "DME Provider") is the DME provider. (Exhibit 1: Prior Authorization Request)

12. [redacted] is the Appellant's primary medical insurance carrier which does not cover the rental of the CPM machine under her benefit plan. [redacted] covered a commode, crutches, and a wheelchair upon discharge. (Appellant's Testimony and Exhibit 9: CPM Rental Agreement)

13. On April 4, 2018, CHNCT received from the DME Provider an authorization request for the rental of the CPM machine for the period [redacted]. Attached to the authorization request was the prescription request for the CPM machine with instructions "[redacted]" (Exhibit 1: Authorization Request)

14. CHNCT requested additional medical information regarding the medical need for the CPM machine from the DME Provider. (Exhibit 2: Medical Review)

15. The DME Provider did not submit additional medical documentation to CHNCT. (Exhibit 2: Medical Review)

16. On [redacted] 2018, CHNCT denied the request for authorization of the CPM machine and notified the Appellant. The notice states that the request for authorization for the rental of a CPM machine has been denied because we did not receive enough information from your provider to show that this service is medically necessary for you. Specifically, the DME Provider must give information to show that you need the CPM machine. CHNCT asked for additional information, but did not receive any additional documentation from the DME Provider. CHNCT cited Connecticut General Statute 17b-259b(a)(5). (Exhibit 3: NOA)

17. On [redacted] 2018, the Appellant requested an administrative hearing to contest CHNCT's denial of the authorization request for the CPM machine. (Exhibit 4: Administrative Hearing Request)

18. On [redacted] 2018, CHNCT issued a notice of appeal to the Appellant. The notice confirmed receipt of the Appellant's hearing request. The notice states CHNCT denied the request for the CPM machine because

CHNCT did not receive the requested clinical documentation that was needed from the DME Provider. The notice provided the Appellant with CHNCT address to submit additional medical documents and informed the Appellant a CHNCT representative will be available during the appeal process. (Exhibit 5: Acknowledgement Letter)

19. On [redacted] 2018, CHNCT issued a notice to the surgeon requesting additional clinical information in order to determine the medical necessity for the CPM machine. CHNCT requested: "Documentation or a letter of medical necessity from the ordering physician regarding the medical need for the requested CPM, documentation of the post-op plan for therapy and or concurrent home exercise program, documentation of the member's post-op weight bearing status and if the member will have limited knee flexion post operatively, documentation that the plan is for the member to use the CPM for a maximum of 21 days, the estimated start date of the CPM, was it applied less than and or up to 40 hours post-surgery." (Exhibit 6: Medical Record Request)

20. On [redacted] 2018, CHNCT receive a letter of medical necessity from [redacted] (the "nurse practitioner"). The nurse practitioner writes, "In an effort to enhance post-operative recovery, we routinely use a CPM to discourage adhesions to and around the capsule of the hip, as well as to prevent stiffness that commonly occurs in any joint with immobilization after a surgery. It has been our clinical experience that the CPM truly optimizes patients' ability to achieve faster mobilization with less post-operative pain and stiffness in the joint than prior to the use of the machine." (Exhibit 7: Clinical Information)

21. On [redacted], CHNCT issued a notice of contact to the Appellant. The notice requested the Appellant contact CHNCT to discuss the appeal. (Exhibit 8: Get in Touch Letter)

22. The Appellant did not reach a CHNCT representative due to her work schedule after several attempts. (Appellant's Testimony)

23. On [redacted] 2018, CHNCT reviewed the authorization request and clinical information provided by the nurse practitioner. CHNCT determined the medical records provided did not support the authorization of the CPM machine as medically necessary. CNHCT requested the following information from the surgeon: "the post-op plan for therapy, the concurrent home exercise program, what is the member start date for the CPM machine, the member's weight bearing status, is the member going to have limited knee flexion post operatively, is the CPM machine planned for a maximum of 21 days? CHNCT denied the Appellant's request for the authorization of the CPM machine because it is not medically necessary

based on an assessment of the Appellant and her medical condition. (Department Representative's Testimony, Exhibit 10: Medical Review Request and Exhibit 11: Medical Review Results)

24. On [redacted] 2018, CHNCT denied the Appellant's appeal of the request for authorization for the CPM machine rental and notified the Appellant. The notice stated the appeal of your request for authorization of the rental of the CPM machine remains denied. The information submitted does not support the medical necessity for the CPM machine. CPM machines are considered medically necessary to improve mobility for total knee replacements. This device was requested for hip surgery. We requested additional information to support the medical necessity for the use of the CPM in your particular case, but it was not received.

CONCLUSIONS OF LAW

1. Connecticut General Statute ("C.G.S.") § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. State statute provides that for purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. [C.G.S. § 17b-259b(a)]

3. State statute provides that clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity. [C.G.S. § 17b-259(b)]

4. State statute provides that upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity. [C.G.S. § 17b-259b(c)]

5. State statute provides that the Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted. [C.G.S. § 17b-259b(d)]

6. Regulations of Connecticut State Agencies ("Regs. Conn. State Agencies") § 17b-262-672 provides that sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of durable medical equipment (DME) to providers, for clients who are determined eligible to receive services under Connecticut Medicaid pursuant to section 17b-262 of the Connecticut General States (CGS).

7. State regulation defines durable medical equipment or DME as equipment that meets all of the following requirements:
   a. Can withstand repeated use;
   b. Is primarily and customarily used to serve a medical purpose;
   c. Generally is not useful to a person in the absence of an illness or injury; and
   d. Is nondisposable. [Regs. Conn. State Agencies § 17b-262-673(8)]

8. State regulation defines prior authorization or PA as approval for the services or the delivery of goods from the department before the provider

actually provides the service or delivers the goods. [Regs. Conn. State Agencies § 17b-262-673(20)]

9. State regulation provides that payment for DME and related equipment is available for Medicaid clients who have a medical need for such equipment which meets the department's definition of DME when the item is prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies. [Regs. Conn. State Agencies § 17b-262-675]

10. State regulation provides that the department shall pay for the purchase or rental and the repair of DME, except as limited by sections 17b-262-672 to 17b-262*682, inclusive, of the Regulations of Connecticut State Agencies, that conforms to accepted methods of diagnosis and treatment and is medically necessary and medically appropriate. [Regs. Conn. State Agencies § 17b-262-676(a)(1)]

    State regulation provides DME services are available to all clients who live at home. Additionally, the department shall pay for ventilators, customized wheelchairs, and Group 2 Pressure Reducing Support Services for residents of nursing facilities and ICF's/MR. [Regs. Conn. State Agencies § 17b-262-676(a)(2)]

11. State regulation provides that when the item for which Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required by the department. The recipient requesting Medicaid coverage for a prescribed item not on the list shall submit such prior authorization request to the department through an enrolled provider of DME. Such request shall include a signed prescription and shall include documentation showing the recipient's medical need for the prescribed item. If the item for which Medicaid coverage is requested is not on the department's fee schedule, the provider shall also include documentation showing that the item meets the department's definition of DME and is medically appropriate for the client requesting coverage of such item. [Regs. Conn. State Agencies § 17b-262-676(a)(4)]

12. State regulation provides that the department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms, or medical history. [Regs. Conn. State Agencies § 17b-262-676(b)(1)]

13. State regulation provides that the Department shall not pay DME providers for: any service or item not identified as covered in sections 17b-262-672

to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, unless it is approved in accordance with section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies. [Regs. Conn. State Agencies § 17b-262-677(5)]

14. State regulation provides that in order to receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met. [Regs. Conn. State Agencies § 17b-262-678(a)]

15. State regulation provides that the department requires prior authorization for: 1) any item identified on the department's published fee schedule as requiring prior authorization; and 2) any item requested under section 17b-262-676(a)(4a) or the Regulations of Connecticut State Agencies. [Regs. Conn. State Agencies § 17b-262-678(b)]

16. State regulation provides that a PA request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and subject to review by the department. [Regs. Conn. State Agencies § 17b-262-678(c)]

17. The Appellant's surgery does not meet the criteria as established in state statute to support the medical necessity of the CPM machine. The evidence submitted does not support the rental of the CPM machine based on an assessment of the Appellant and the surgery performed. Evidence submitted failed to address the medical need for the requested CPM machine, the prognosis and rehabilitative potential after surgery, the post-op plan for therapy, a home exercise program, and substantiate the reason for the recommended length of use or 21 days.

18. The Appellant's surgery does not meet the criteria to authorize payment for the rental of the CPM machine because the Appellant has not substantiated the need for the CPM machine rental as medically necessary.

19. CHNCT was correct to deny prior authorization request because the Appellant does not meet the medical necessity criteria for the rental of the CPM machine in accordance with state statutes and regulations.

20. On [redacted] 2018, the CHNCT correctly denied the Appellant's request for prior authorization of the rental of a CPM machine and issued a notice of denial to the Appellant.

DISCUSSION

Although the rental of the CPM machine may enhance post-operative recovery, there is not enough evidence to support the medical necessity for the rental of the CPM machine. At the administrative hearing, the Appellant testified there is a family history of a blood clotting disorder and the surgeon recommended the use of the CPM machine along with medication to reduce this risk of forming a blood clot after surgery. However, neither the Appellant nor her surgeon submitted evidence of such a risk to CHNCT. Based on the medical evidence provided, CHNCT correctly denied the Appellant's request for prior approval of the rental of the CPM machine.

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Fair Hearing Officer

CC: CHNCT, appeals@chnct.org
Fatmata Williams, DSS, Central Office

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.