STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Appellant
______________________/

Docket No. 2009-10963 PA
Case No.

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on . , appeared on behalf of the Appellant. The Department was represented by Medicaid analyst, . Witnesses for the Appellant included her physical therapist, .

ISSUE

Did the Department properly deny Appellant's request for prior authorization (PA) of a customized power wheelchair?

FINDINGS OF FACT

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

1) At the time of hearing the Appellant is a Medicaid beneficiary.

2) The Appellant resides in a nursing facility. She is entirely dependent on a wheelchair for mobility as she is unable to walk at all. She has suffered with Multiple Sclerosis for over .

3) The Appellant currently uses a power scooter with Captain's chair purchased by her family prior to becoming eligible for Medicaid. She is no longer able to use it functionally due to her medical condition. She has poor trunk strength and abnormal posture, fair head position resulting in head bend downwards, pelvic tilt, abducted leg position, moderate

kyphosis and rounded shoulders. Her condition is progressive and not expected to improve.

4) The Appellant owns a manual wheelchair she is able to self propel 20 feet over tiled surfaces only. Fatigue limits her ability to propel it further distances.

5) The Appellant is at risk for skin ulcers due to her urinary incontinence and inability to ambulate or shift position without assistance.

6) The Appellant, through her medical supplier, has requested a Quantum 600 power wheelchair with customized seating, power tilt and other customized accessories.

7) The Department denied the request stating in its denial notice that the requested information had not been provided. The Department agreed at hearing a power wheelchair could be approved, but not one with a power tilt function.

8) Provision of the wheelchair, as requested, would allow the Appellant to perform and assist in completing her activities of daily living and (ADL's) and Instrumental Activities of Daily Living (IADL's). It would further allow her independent mobility throughout the nursing facility without need for an aid.

9) While seated in a wheelchair without a tilt mechanism, the Appellant's head is bent, preventing her from sitting comfortably or full participation in IADLs.

10) A wheelchair with a seat placed in a stationary, or permanent tilt position results in degradation of abdominal muscles due to inability to reposition and lack of ability to see the ground; making operation of the power chair unsafe.

11) The Appellant has established medical necessity for the power wheelchair with all accessories requested, including a power tilt.

12) The Appellant meets all Standards of Coverage as stated in the Medicaid Provider Manual, except, for the power tilt mechanism.

13) The Department has denied a request for medically necessary durable medical equipment based upon the Appellant's residence, a nursing home.

14) The Appellant timely requested a hearing on the matter, through her hearing representative, [redacted].

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.

The Medicaid Provider manual sets forth the Standards of Coverage for requested medical procedures, supplies and equipment. In order to be a Medicaid covered service, the request must be medically necessary and meet standard of coverage parameters. Medical Necessity is addressed therein as follows:

> **1.5 MEDICAL NECESSITY**
>
> Services 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. A service is determined to be medically necessary if prescribed by a physician and it is:
>
> - Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
> - Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
> - Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
> - Inappropriate to use a non-medical item.
> - The most cost effective treatment available.

Further, the Medicaid Provider Manual (MPM) establishes the procedures for PA and supporting documentation:

> **PRIOR AUTHORIZATION**
>
> Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-made DME or prosthetic/orthotic appliances, before the item is ordered . . . .
>
> PA will be required in the following situations:
>
> - Services that exceed quantity/frequency limits or established fee screen.
> - Medical need for an item beyond MDCH's Standards of Coverage.

- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required on the MDCH Medical Supplier Database.

PRIOR AUTHORIZATION FORM

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). . . . in addition, medical documentation (e.g., prescription, CMN, letter or other) must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must provide the specific HCPCS code and the HCPCS code description. If the service falls under a NOC code, a complete description of the service and/or specific materials and labor time, if applicable. The prescription must be submitted with the request . . . . PA request forms and attached documentation may be mailed or faxed to the MDCH Prior Authorization Division . . . .

The various models of wheelchairs require model specific information and medical rationale including current documentation:

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY ITEMS AND SEATING SYSTEMS

Definition A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, lightweight high strength, powered, etc.

A pediatric mobility item (wheelchair/stroller) has special lightweight construction consisting of a frame and wheels with many different options and includes, but is not limited to, transport chairs.

Seating systems are systems to facilitate positioning in a wheelchair. These include, but are not limited to:

- Standard or planar prefabricated components or components assembled by a supplier or ordered from a manufacturer who makes available special features, modifications or components.
- Contoured seating is shaped to fit a person's body to provide support to facilitate proper posture and/or pressure relief. Contoured seating is not considered custom-made.

- Custom seating is uniquely constructed or substantially modified to meet the specific needs of an individual beneficiary.

A standing wheelchair is a wheelchair that incorporates a standing mechanism that may be self-propelled by the user for mobility. It allows an individual to go from a seated position to a standing position with either a manual level or power switch.

Standards of Coverage – Wheelchairs

For beneficiaries residing in their own home, AFC or Assisted Living, manual wheelchairs will be covered if the beneficiary demonstrates all of the following:

- Has a diagnosis/condition that indicates a lack of functional ambulatory status.
- Must be able to regularly use the wheelchair throughout the day.
- Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury.
- Must have a method to propel wheelchair, which may include:
    - ➢ Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces.
    - ➢ Willing, able, and reasonable caregiver to push the chair if needed.

A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required.

A **lightweight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance.

A **heavy-duty wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds.

An **extra heavy-duty wheelchair** is covered if the beneficiary's weight exceeds 300 pounds.

A **high strength lightweight, ultra-light or an extra heavy-duty wheelchair** may be covered when required for a specific functional need.

Back Up or Secondary Manual Wheelchair may be considered when:

- The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living.
- The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.

Power Wheelchairs or Power Operated Vehicles (POV) may be covered if the beneficiary demonstrates all of the following:

- Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual one for at least 60 feet over hard, smooth, or carpeted surfaces.
- Requires the use of a wheelchair for at least four hours throughout the day.
- Able to safely control a wheelchair through doorways and over thresholds up to one-and-one-half inches (e.g., the beneficiary's cognitive and physical abilities to safely operate the wheelchair).

MDCH may consider coverage of a POV, including custom or modified seating, rather than a more expensive power wheelchair if the beneficiary has sufficient trunk control and balance necessary to safely operate the device.

Wheelchair Accessory may be covered if medically necessary to meet the functional needs of the beneficiary. Specific accessories are part of the initial purchase of a wheelchair and should not be billed separately. Other accessories/modifications are considered as upgrades and would require medical justification from physician, occupational or physical therapist. Specific wheelchair accessories requested solely to facilitate transport of a beneficiary within a vehicle are not covered.

The physician, occupational or physical therapist must address the status/condition of the current chair and include the brand, model, serial number and age of current chair.

Standard and Custom-Modified Versus Custom-Made - Standard, custom-modified, or custom-made wheelchairs must be medically necessary and meet the intended purpose.

Custom-modified refers to modifications to a standard wheelchair item to meet specialized needs of a beneficiary by using prefabricated parts (e.g., addition of a strap to a standard item).

A **custom-made wheelchair** is fabricated to meet the functional needs of one specific person. The item is specifically made to fit one user based on direct measurements or body castings. It may involve the incorporation of some prefabricated components but the majority of the device is fabricated specifically for the user. Structural modification beyond the initial fabrication may be required to ensure the desired fit and functionality.

MDCH will consider coverage of custom-made equipment when a standard or custom-modified item will not meet the medical and/or functional needs of the user.

For beneficiaries under 21, **stand-up wheel chairs** may be covered if:

- Medical documentation supports the need for standing daily and it is ordered by a pediatric specialist.
- Other economic alternatives have been ineffective.

A **pediatric mobility item (wheelchair/stroller)** may be covered for children ages three and over when:

- The requested item will be the primary mobility device for a child who cannot self propel a manual wheelchair or operate a power wheelchair.
- Diagnosis or medical condition effects resulting in the ability to ambulate.
- It is required as a transport device when primary wheelchair is not portable and cannot be transported.

Standard or planar seating systems are covered when necessary to assure appropriate positioning in a wheelchair, other economic alternatives have been ineffective, and beneficiary has one of the following conditions:

- Postural deformities
- Contractures
- Tonal abnormalities
- Functional impairment
- Muscle weakness
- Pressure points
- Difficulties with seating balance

Payment for a seating system includes all repairs and modifications for a two-year period for beneficiaries of all ages.

Custom fabricated seating systems are covered when both of the following apply:

- The criteria for standard seating system has been met.
- A comprehensive written medical evaluation substantiates that a prefabricated seating system is, or would be, inadequate to meet the beneficiary's needs.

Payment for a seating system will be based on the least costly alternative that meets the beneficiary's medical needs. Payment for the seating system includes all repairs and modifications for a two-year period for beneficiaries of all ages.

Standards of Coverage – Wheelchair Modifications

Manual or Power Recline may be covered when needed for relief of pressure on the seat and/or back and one of the following applies:

- History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques.
- Has ability to tolerate a 90 – 135 degree of range of motion at the hip needed for reclining without triggering excessive abnormal tone.
- Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved.

A low shear recline back is covered when the beneficiary does not have the ability to reposition himself in the chair following reclining and the shearing would result in skin breakdown.

Tilt-in-Space function allows the seat and back of the wheelchair to move as a unit such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually or by power.

The tilt-in-space modification to a wheelchair may be covered if one or more of the following apply:

- History of skin breakdown or current indication of skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques.

- Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective and a reason why changing angles of position is medically necessary.
- Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies.
- Beneficiary has knee contractures and has a custom molded seating system.

Coverage of a joint **tilt-in-space and recline modification** to a wheelchair requires medical need such as high probability of the development of hip contractures if only a tilt-in-space without recline is used. There also needs to be a medical contraindication to recline only without tilt-in-space.

A **power driven recline mechanism or tilt-in-space** may be covered if:

- Beneficiary requires assistance to use a manual tilt-in-space or recline system and there are regular periods of time that the beneficiary is without assistance.
- Beneficiary requires assistance to use a manual tilt-in-space or recline system and is able to independently care for himself when provided a power recline or tilt-in-space modification.
- Beneficiary resides in a nursing facility and use of a power tilt-in-space will permit movement to a less restrictive setting (i.e., the resident being discharged to their own home or other assisted living option available in the community).

For **beneficiaries residing in a nursing facility,**

- Standard DME is included in the facility's per diem rate.

Custom fabricated DME required for the beneficiary's full time use is billable by a medical supplier. The custom made DME must offer physical/restorative function to the beneficiary and allow for independence in the nursing facility setting that is not possible with standard DME (i.e., the item will allow the resident to be mobile without the assistance of an aide, nurse or other staff). Once the custom made equipment is purchased, it becomes the property of the beneficiary.

Medicaid Provider Manual; Medical Supplier
Version Date: April 1, 2009; Page 79-83

The Department witness, [redacted] asserted at hearing a power wheelchair could be approved for the Appellant, however, not one with a power tilt function. She asserts this cannot be provided to any resident of a nursing facility unless there is documentation

that the resident is leaving the nursing facility to move to a less restrictive setting. She cites the Medicaid Provider Manual Standards of Coverage in support of the denial.

The evidence from the Appellant's representative and witness, including the Appellant's physical therapist, establishes the Appellant has requested medically necessary durable medical equipment. The evidence contained in the Department's exhibit at pages 32-40 details her medical condition and reasons the requested chair is necessary. They include her abnormal posture, pelvic tilt, hip and knee flexion, lumbar mobility, trunk control neck positioning and lack of strength. It is uncontested she suffers from a progressive, debilitating disease, is wheelchair dependent and has no ability to ambulate on her own.

After review of the written policy contained in the Medicaid Provider Manual for wheelchair coverage, it is clear the Policy specifically excludes residents of nursing facilities coverage for a power driven recline mechanism or tilt in space, regardless of the medical necessity for it. It states **only for residents of nursing facilities**, that coverage of the power driven tilt in space may be covered if it will permit movement to a less restrictive setting (i.e., the resident being discharged to their own home or other assisted living option available in the community). The policy does not consider the medical necessity of the mechanism or any other factor, simply whether purchase of a chair with this function will allow discharge of the resident. In other words, if the Appellant were to reside in an adult foster care home or other "less restrictive setting," after establishing medical necessity and meeting coverage guidelines, the power driven tilt in space would be covered, along with the chair. However, based solely upon the fact that she is a resident of a nursing facility, the power driven tilt in space is denied, regardless of whether it is a medically necessary component of the wheelchair. It is not known whether this restrictive policy is aimed at nursing home residents or nursing facilities, but this ALJ is without authority to disregard the Policy as written, even in the face of strong evidence of medical necessity. Because Department Policy has specifically written an exclusion for residents of nursing facilities and the Department has stipulated a power wheelchair could be covered without the requested power driven tilt in space, further discussion is moot.

The chair, as requested, was denied by the Department based upon their written Policy. This ALJ cannot overturn the written Policy, as to do so extends beyond the jurisdiction or reach of the very limited authority possessed. The role of the ALJ is to ensure a fair hearing. A fair outcome cannot be ensured by the Administrative hearing process as application of Policy, whether fair or not, is the only authority possessed by the Administrative Law Judge. This ALJ regretfully must sustain the determination of the Department to deny the medically necessary medical equipment because the Standards of Coverage specifically exclude the Appellant from coverage for the power driven tilt in space component of the wheelchair based upon the fact that she resides in a nursing facility.

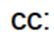
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds the Department's denial is supported by its own Policy.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: 

Date Mailed: 4/13/2009

***** NOTICE *****
The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.