**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-14480 QHP
Case No. [redacted]
Load No. [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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on her own behalf.

[redacted], appeared on behalf of [redacted] ('Medicaid Health Plan' or 'MHP'). Also appearing as witnesses for the MHP was [redacted].

## ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for a power wheelchair?

## FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary, and is enrolled with [redacted], a Medicaid Health Plan. According to comments included in the Request for Hearing, the Appellant suffers from morbid obesity, right arm/hand weakness due to ulnar neuropathy, and pain in her legs and knees due to degenerative joint disease. *(Exhibit 1, p. 11; Request for Hearing)*

2. On [redacted], the MHP denied the Appellant's request for a power wheelchair, as the information submitted with the prior authorization request did not include documentation regarding the Appellant's upper extremity strength and the inability to propel a manual wheelchair.

3. The Appellant submitted to the MHP's internal appeals procedure, after which time the MHP appeals committee upheld the denial.

4. The medical documentation submitted to the MHP in support of the motorized wheelchair concerns an outpatient physical therapy evaluation and treatment form for the lower extremities. *(Exhibit 1, pp. 13-15)*

5. On [redacted] the Appellant filed her request for hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

## 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.

On May 30, 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 Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverage(s) and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
>
> ***Article II-G, Scope of Comprehensive Benefit Package. MDCH contract Contract) with the Medicaid Health Plans, September 30, 2004.***

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
>
> - Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
> - A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
> - Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
> - An annual review and reporting of utilization review activities and outcomes/interventions from the review.
>
> The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverage(s) established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> ***Article II-P, Utilization Management, Contract, September 30, 2004.***

Fee-for-service Medicaid beneficiaries are subject to the prior approval process found in the Medicaid Provider Manual. MHP beneficiaries are entitled to the same or equivalent benefits as fee-for-service Medicaid beneficiaries.

Wheelchairs are covered under certain circumstances, described as follows:

> **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**

**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:

    1. Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces.
    2. Willing, able, and reasonable caregiver to push the chair if needed.

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The MHP has adopted criteria set forth in its Utilization Guidelines. Although the MHP's contract with the Department allows it to adopt criteria for the coverage of goods and/or services different from that found in the Medicaid Provider Manual, the criteria may not be used to deny otherwise medically necessary services, in practice, may not deny a service that fee-for-service beneficiaries would otherwise receive.

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

**Does the Appellant meet criteria for coverage of a motorized wheelchair?**

Here, the MHP covers a motorized wheelchair when the patient/caregiver is unable to safely and efficiently propel a standard manual wheelchair, or has a medical condition that would be compromised by propelling a manual chair for at least 60 feet over hard, smooth or carpeted surfaces.

Fee-for-service Medicaid beneficiaries must demonstrate they lack the ability to propel a manual wheelchair, or that they have a medical condition that would be compromised by propelling a manual chair for at least 60 feet over hard, smooth, or carpeted surfaces.

It appears the MHP coverage requirements do not significantly depart from policy dictates imposed upon fee-for-service Medicaid beneficiaries. Accordingly, I conclude the policies are consistent, in both form and effect.

Both Fee-for-service and MHP beneficiaries must supply medical documentation concerning the limitations of the upper extremities for purposes of propelling a standard wheelchair. Here, the Appellant has submitted medical documentation concerning a lower extremity physical therapy evaluation. That evaluation addresses the Appellant's lower extremities, and concludes that rehabilitation potential is "good." *(Exhibit 1, p. 15)*

Other documentation submitted by the Appellant in support of her request for hearing includes a

copy of the physician's order, a prescription form for an electric wheelchair with diagnoses of pain and gait ataxias, a Wright and Filippis customer quote, and an Environmental Mobility Assessment.

These documents, however, convey no information regarding the strengths and limitations of the Appellant's upper extremities, and are afforded little weight.

The Appellant testified her obesity and other physical ailments make it difficult to propel her existing manual wheelchair. While this may be true, she failed to submit the required physical therapy evaluation regarding her ability to propel a manual chair. As such, she has failed to fulfill policy criteria applicable to eligibility for a motorized wheelchair.

## DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that the MHP has appropriately denied the Appellant's request for a motorized wheelchair.

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/11/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.