STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-34338 QHP
Case 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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's authorized hearing representative, appeared and testified on behalf of Appellant. [redacted] Director of Customer Service for [redacted], represented the Medicaid Health Plan (MHP). [redacted], a Registered Nurse; and [redacted] a Grievance Appeals Coordinator, testified as witnesses for the MHP.

ISSUE

Did the MHP properly determine that Appellant does not meet the eligibility criteria for a power operated vehicle (POV)?

FINDINGS OF FACT

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

1) Appellant is a [redacted] Medicaid beneficiary who resides in a nursing home.

2) Appellant was given a primary diagnosis of arthritis. (Exhibit 1)

3) According to [redacted] Progress Reports: Appellant cannot walk long distances, more than 10 minutes; Appellant uses a cane in her home and can walk 156 feet at home; Appellant has

difficulty walking long distance out of her house; Appellant has arthritis, and a deformity of her left hand that interferes with the ability to use a standard wheelchair; and a power scooter was recommended for use outside of Appellant's home. (Exhibit 1, pp. 6, 11 & 12)

4) On or about [redacted], [redacted] received a prior authorization request for an electric scooter from Appellant's primary care physician. (Exhibit 1, p. 1)

5) On [redacted] [redacted] sent Appellant written notice that the request for the power scooter had been reviewed by their physician and was denied because Appellant is able to walk with a cane and perform activities of daily living (ADL's) within her home. (Exhibit 1, p. 2)

6) On [redacted], the State Office of Administrative Hearings and Rules received Appellant's hearing request, protesting the denial of a power scooter.

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.

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

> **CUSTOMIZED EQUIPMENT**
>
> For customized equipment, the durable medical equipment provider must request prior authorization (PA). Once purchase or rental of the equipment is authorized, the DME/Medical supply provider may provide the service and bill Medicaid directly.
>
> PA is approved if the following conditions are met:
>
> - The attending physician (M.D. or D.O.) must order the equipment in writing. These orders must be signed by the attending physician and retained in the beneficiary's medical record. The orders must include the estimated period of months that the beneficiary will need such equipment, the medical/functional need, and an explanation of why standard, non-customized equipment is not suitable. A copy of the physician's orders must be attached to the durable medical equipment provider's prior authorization request.

- The equipment is medically necessary and specifically customized for the exclusive use of the beneficiary.

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. . . .

Medicaid Provider Manual; Nursing Facility Coverages; Version Date: July 1, 2009

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

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 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 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 put to one-and one-half inches.**

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. Has a diagnosis/condition that indicates a lack of functional ambulatory status.

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 a physician, occupational or physical therapist…

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.

A **custom-made wheelchair is fabricated to meet the functional needs of one specific person…**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.

Standard or planar seating systems are covered when necessary to assure appropriate positioning in a wheelchair, other economic alternative 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.

Noncovered Items

- Secondary wheelchairs for beneficiary preference or convenience.
- Standing wheelchairs for beneficiaries over 21 years old.
- Coverage of power tilt-in-space or recline for a long-term care resident because there is limited staffing.
- Non-medical wheelchair accessories such as horns, lights, bags, etc.
- New equipment when current equipment can be modified to accommodate growth.

Documentation The documentation must be within 180 days, and include the following:

- Diagnosis appropriate for the equipment requested.
- Occupational therapy or physical therapy evaluation and recommendation.
- Brand and model of requested wheelchair.
- If a replacement wheelchair is requested, list brand, model, serial number and age of current chair.
- Medical reason for add-on components or modifications, if applicable.
- Specific medical condition (e.g., contractures, muscle strength) if seating system requested.
- Current ambulatory status of beneficiary (e.g., distance the individual can walk, the level of assistance required).
- Any adaptive or assistive devices currently used (if replacement chair is requested, list brand, model, serial number and age of current chair).
- Other cost-effective alternatives that have been ruled out.

- A pediatric subspecialist is **required under the CSHCS Program**.

Medicaid Provider Manual; Medical Supplier
Version Date: July 1, 2009

In this case, Appellant primary care physician requested a power scooter on Appellant's behalf. According to [redacted] Progress Reports: Appellant cannot walk long distances, more than 10 minutes; Appellant uses a cane in her home and can walk 156 feet at home; Appellant has difficulty walking long distance out of her house; and Appellant has arthritis, and a deformity of her left hand that interferes with the ability to use a standard wheelchair. Appellant's representative does not dispute the Department's determination that Appellant does not meet the eligibility for a standard manual wheelchair. However, he argued that Appellant does meet the eligibility criteria for a power wheelchair or power operated vehicles (POV), and the Department improperly denied Appellant's request for a power scooter that is needed for use outside of her home.

"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." (Medicaid Provider Manual; Medical Supplier section, Version Date: July 1, 2009) The eligibility criteria for a power wheelchair or POV are found within the wheelchair policy of the Medicaid Provider Manual. A power wheelchair or POV is one of many categories of wheelchairs that a client may qualify for. If a client does not meet the eligibility for a standard wheelchair, he/she will not qualify for a power wheelchair or POV. A power wheelchair/POV is considered a type of wheelchair that the beneficiary may qualify for if he/she requires a wheelchair for ambulation, and the standard wheelchair does not meet a beneficiary's particular functional needs.

In this case, the Department properly denied Appellant's request for a POV on the basis that she does meet the eligibility criteria for a wheelchair. The objective medical evidence on the record establishes that Appellant has functional ambulatory status as she is able to walk short distances with a cane. Further, the MHP submitted additional Medicaid policy which supports its denial of Appellant's request. According to the information that was submitted with the prior authorization request, Appellant uses a cane within her home, but needs a POV outside the home. Medicaid policy states clearly that Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use only in the Medicaid beneficiary's place of residence except for skilled nursing or nursing facilities. (Medicaid Provider Manual, Medical Supplier section, Version Date: July 1, 2009).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for a POV.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/28/2009

***** 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.