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. 2009-36824 PA
[redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; MSA 16.409 and MCL 400.37; MSA 16.437, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared as Authorized Representative for [redacted] (Appellant).

[redacted], Medicaid Utilization Analyst, represented the Michigan Department of Community Health (Department).

ISSUE

Did the Department properly deny Appellant's prior authorization request for a Convaid Cruiser 16" stroller with accessories, HCPCS Code D1236?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence, the Administrative Law Judge finds as material fact:

1. Appellant is a Medicaid beneficiary with diagnoses of congenital anomaly and cerebral palsy. *(Exhibit 1, p. 33)*

2. On [redacted], the Appellant requested a Convaid Cruiser 16" stroller with accessories, HCPCS Code E1236. The Department returned the request on [redacted] requesting additional information.

3. The Prior Authorization request was re-submitted on [redacted]. On [redacted], the Department denied the requested equipment, with a letter that indicates the type of mobility item requested is authorized for 0-20 year old individuals, and that only one (1) chair may be authorized with a 5-year period.

4. The Appellant is currently provided with a pediatric wheelchair (E1236) with accessories that was approved on [redacted]. Additionally, she was provided a Quickie 2 Manual Wheelchair (K0005) with accessories on [redacted].

5. The Department denied the Convaid Cruiser 16" stroller with accessories because it duplicates the equipment approved in 2005, and is coded as a pediatric product, covered for beneficiaries, ages 0-20. The Appellant is [redacted].

6. 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.

> For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. The following items are exempt from the per diem rate and may be billed by the medical supplier:
>
> - Air-fluidized beds
> - Bariatric beds
> - Custom-made wheelchairs may be covered when standard DME does not meet the functional needs of the beneficiary, is required for independence, and if it can only be used by the specific beneficiary. (If purchased by Medicaid, the equipment becomes the property of the beneficiary.)
>
> (Reference Section 9.8.B; Medicaid Provider Manual; Nursing Facility Coverages; p. 36)
>
> - Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis)
> - Orthotics and Prosthetics
> - Parenteral nutrition, including all supplies, equipment, and solutions
> - Powered air flotation bed (low air loss therapy)

- Selected surgical dressings (Refer to the MDCH Medical Supplier Database for specific procedure codes.)
- Shoes and Additional Components

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.

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:
- 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.

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**.**

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.

Non-covered 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 sub-specialist is **required under the CSHCS Program**.

Medicaid Provider Manual; Medical Supplier
Version Date: October 1, 2009, Pages 3; 9; 79-81

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).

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).

The preponderance of the evidence presented supports the Department's denial. The evidence establishes that the Appellant is [redacted] of age and therefore no longer a child. She therefore is not entitled to pediatric mobility equipment that, by policy, is limited to "children" ages three and over.

The specific equipment requested (E1236) is listed on the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database as a "Folding Pediatric Wheelchair-Adjustable." *(Exhibit 1; p. 20)* The DME Classification documentation published by Medicare describes the equipment as a "Wheelchair, Pediatric Size, Folding, Adjustable, with Seating System." *(Exhibit 1; p. 19)* It therefore appears the specific equipment requested is limited to children, ages 3 and over. The classification of a child ends at age 18---the [redacted] Thus, she is no longer a child and ineligible for a pediatric wheelchair.

Although a preponderance of the medical evidence demonstrates the Appellant has a medical need for a wheelchair *(Exhibit 1; pp. 35-36),* and other evidence suggests her existing chair may be worn, damaged or both, the fact remains she has requested a pediatric mobility item for which she is no longer eligible due solely to her present and status as an adult.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Department's denial of Appellant's prior authorization request for the requested equipment and accessories is proper.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 12/3/2009

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.