**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. 2009-36857 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.*, following the Appellant's request for a hearing.

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

[redacted] appeared on behalf of the Clinical Appeals Department of [redacted] ('Medicaid Health Plan', or 'MHP'). Also appearing as a witness for the MHP was [redacted] T.N., Team Leader, Medical Management Department.

## ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for power operated vehicle (POV)?

## FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary, who is enrolled with [redacted], a Medicaid Health Plan. Her medical diagnoses include chronic obstructive pulmonary disease hypoxia and morbid obesity. *(Exhibit 1; pp. 2, 4)*

2. On [redacted], the MHP received a prior authorization request for a power operated vehicle (POV). The only documentation submitted with the request was the prior authorization request form and a prescription. *(Exhibit 1; pp 2-3)*

3. The MHP spoke with the office of Appellant's physician, [redacted] regarding the request. Per [redacted], he does not want the Appellant to have a power scooter or power wheelchair, and advised the Appellant of that position, but that he wrote her a prescription nonetheless at her insistence.

4. The MHP referred the prior authorization request to a physician for review and determination. The request for approval was denied based on a lack of clinical information to support the medical necessity for the request, as well as on [redacted] statement that he does not want the Appellant to have a POV and will not sign a certificate of medical necessity.

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 coverages 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 coverages 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*

With regard to medically necessary covered services, the Medicaid Provider Manual provides, in pertinent part, 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.

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**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.

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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 that 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).

In contrast, the MHP credibly testified the physician told them he does not want her to have a POV and only issued a prescription after being pressured by the Appellant to do so. This assertion, combined with the fact that the record contains no certificate of medical necessity, supports my conclusion that the Appellant has failed to carry her burden of establishing medical necessity for the requested equipment.

## DECISION AND ORDER

Because the Appellant bears the burden of proving entitlement to a medically necessary service, and because she did not present any legally sustainable challenge to the MHP's assertion the requested equipment is not medically necessary, I conclude the MHP has appropriately denied the Appellant's request for a POV.

**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: 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 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.