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. 2009-5561 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] appeared as Authorized Representative for [redacted] (Appellant).

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

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for a motorized scooter?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary, currently enrolled with [redacted] a Medicaid health plan. Her medical conditions include iron deficiency anemia; lupus pneumonitis; pulmonary hypertension, and debility. As of [redacted], she weighs [redacted] lbs.

2. On [redacted] the Appellant's primary care physician requested prior authorization for a motorized scooter. On [redacted], the MHP denied the Appellant's request for a motorized scooter.

3. The Appellant's medical conditions cause her difficulty with ambulation outside of the home; she is requesting the motorized scooter for assistance in performing tasks such as shopping. *(Exhibit 1; p. 7)*

4. 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

1.10 NONCOVERED ITEMS

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Enteral formulae to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Hand/body wash
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Ice packs

- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g., insulin pump)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional formulae representing only a liquid form of food
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Peri-wash
- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- Room dehumidifiers
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second units for school use
- Second wheelchair for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formulae
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Thickeners for foods or liquids (e.g., Thick – it)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- Ultrasonic osteogenesis stimulators
- UV lighting for Seasonal Affective Disorder
- Vacu-brush toothbrushes
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

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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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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.
- For social or recreational purposes

The Appellant's representative testified the Appellant's medical conditions cause her difficulty with any physical activity, and that she therefore can walk only a few steps before having to rest. The Appellant's representative further testified the Appellant experiences difficulty ambulating both inside and outside of the home, but acknowledges having no medical documentation to support these claims, other than what is already contained under *Exhibit 1*.

The MHP relied upon medical documentation submitted by [redacted] which states the Appellant *"…is having difficulty ambulating to do shopping and she is asking for a motorized wheelchair or some other device to help her with that…" (Exhibit 1; p. 7)* Based on this comment, the QHP concluded the equipment is a non-covered service, and denied coverage.

The MHP has established internal criteria for approval of power wheelchairs from an outside source (Interqual), and has further adopted the criteria as part of its internal certificate of

coverage.

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.

Here, with regard to coverage of a scooter, the MHP requires a patient's condition to be such that without the use of a power-operated vehicle, the patient would not be able to move around their residence. The MHP coverage guidelines explicitly exclude coverage for a power-operated vehicle that will be used outside of the home.

Of note is that Fee-for-service, or straight, Medicaid beneficiaries need only show they lack the ability to propel a manual wheelchair, or that they have a medical condition that would be compromised by propelling a manual one for at least 60 feet over hard, smooth, or carpeted surfaces. Fee-for-service beneficiaries must also be able to demonstrate the equipment is not to be used for social or recreational purposes. Provider Manual policy does not specifically restrict coverage to those who only intend on using the vehicle while inside the home. It provides only that coverage is excluded if the vehicle is used for social or recreational purposes.

When comparing fee-for-service criteria for coverage of power wheelchairs with that of the MHP, it appears the MHP's criteria are significantly more restrictive concerning when it will cover this piece of equipment. In this regard, I conclude the differences between fee-for-service criteria, and the criteria imposed by the MHP to be significant, and suspect the MHP's criteria may not withstand medical necessity scrutiny if medical documentation otherwise supports a conclusion the scooter is necessary.

All of which leads me to the question, is shopping a social and/or recreational activity? I conclude it is, or can be, both. Shopping is considered an activity of daily living, a task for which Medicaid dollars are used to compensate care providers under the Adult Home Help Service program. Shopping also includes leisure shopping, which obviously would be considered social and/or recreational.

In the case at bar, I conclude the MHP has improperly based its denial of an otherwise covered service or equipment on the comment that the vehicle will be used outside of the home. The MHP has bypassed its responsibility, as a Medicaid Health Plan, to evaluate the Appellant's ambulatory status for coverage of a motor scooter that may, in fact, be used by the Appellant while inside the home.

The fact that the motorized scooter may occasionally be used outside of the home is not controlling. Rather, if the Appellant may benefit from the use of a motorized scooter, for purposes of addressing non-social or recreational concerns, the scooter is covered durable medical equipment, for which the MHP is responsible to pay.

A determination must ultimately be made as to whether the Appellant in this case has established she meets criteria for coverage of a power scooter. Implicit in both fee-for-service and MHP criteria is a requirement that the Appellant present medical documentation in support of her

contention she has a medical condition that renders her unable to propel a manual wheelchair, or that this condition might be compromised by propelling a manual chair for at least 60 feet over hard, smooth, or carpeted surfaces.

The Appellant presented medical documentation that identifies certain medical conditions (overweight, Pulmonary Hypertension and lupus). All of those conditions have interfered with her ability to ambulate. Additionally, the Appellant's physician describes a fourth condition, debility, or the inability to ambulate due to a feebleness or weakened state, as a primary reason why the Appellant would benefit from a motorized scooter. *(Exhibit 1; p. 7)*

Because the MHP has failed to completely evaluate and determine the Appellant's eligibility for a power scooter under Medicaid Provider Manual policy, it is impossible to ascertain at this time whether the Appellant has or has not met criteria for the requested equipment.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

The Medicaid Health Plan shall arrange and pay for an assessment on the Appellant to determine whether, under applicable Medicaid Provider Manual policy, she meets criteria for a motorized power scooter.

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

cc: [redacted]

Date Mailed: 2/23/2009

***** 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.