STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-15584 QHP
[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] appeared on behalf of the Appellant, who was present and testified. [redacted], member services manager, represented the Medicaid Health Plan (MHP). Her witness was Medical Director, [redacted]

ISSUE

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

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]d Medicaid beneficiary who is enrolled in the [redacted].

2. The Appellant is afflicted with the residuals of a double amputation [above the knee], phantom limb syndrome and chronic pain. He is also afflicted with COPD. (*See* Testimony and Respondent's Exhibit A, pp. 11, 12)

3. On [redacted], the MHP received Appellant's request for a power wheelchair. (Respondent's Exhibit A, p. 8)

4. On or about [redacted], the MHP advised the Appellant that his request for the power wheelchair was reviewed and denied because of a lack of supporting evidence or evaluation demonstrating that he is unable to self-propel in a manual wheelchair. (Exhibit A – throughout)

5. There was no documentary evidence to establish that the Appellant was unable to roll (self-propel) a manual wheelchair. (Respondent's Exhibit A, p. 12)

6. On [redacted], the instant request for hearing was received by SOAHR as prepared by the Appellant [redacted]. (Appellant's Exhibit #1)

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 [redacted], 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. 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 I-Z.
>
> . . . .

Although the Contractor must provide the full range of Covered Services listed below they may choose to provide services over and above those specified.

The services provided to Enrollees under the Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning Services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially, pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)

- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under 21.

Article II-G. Scope of Comprehensive Benefit Package, contract, 2008, p. 32.

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 utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.

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, p. 66.

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Appellant's representative explained that the Appellant needs a power wheelchair because "the one he has now is a very light chair" and that the powered chair he has borrowed from his church is "wobbly" so he tends to fall off the chair. Additionally, he has to return it to the church. She added that it is "obvious" that he cannot self propel.

The MHP Medical Director testified that the one item missing, but necessary for MHP approval, was documentation of the 60-foot [attempted] self-propulsion test.

The Appellant's own exhibit, however, revealed that on evaluation he misled his physical therapist about his then present state of abilities - out of anger. Irrespective of his anger the physical therapist recommended a power chair for the Appellant in her written report – when or whether the self propulsion test was administered was not reflected in any communication from the therapist or the Appellant's physican. See Appellant's Exhibit #1

The MHP denied Appellant's request for a power wheelchair owing to a lack of adequate medical documentation and lack of medical necessity. Specific evidence of an evaluation wherein the Appellant was tested to determine if he could self-propel a manual wheelchair was lacking from his proofs. The requirement is clearly articulated in the MHP utilization guideline for motorized scooters and wheelchairs. *See* Respondent's Exhibit A, p. 5.

The decision to deny a power wheelchair on review of the evidence available was clearly supportable and within the MHP's reasonably drawn utilization guidelines.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/12/2010

***** 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.