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. 2010-41995 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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], appeared on her own behalf. Her housekeeper, [redacted], appeared as a witness for the Appellant. The Medicaid Health Plan (MHP), [redacted] was represented by Senior Attorney, [redacted]. Medical Director, [redacted], appeared as a witness for the MHP.

ISSUE

Did the MHP properly determine that the Appellant does not meet the eligibility criteria for a power wheelchair?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary and has been enrolled in the MHP since [redacted]. (Exhibit 2, page 5)

2. The Appellant is a [redacted] woman with a history of morbid obesity and severe osteoarthritis. (Exhibit 1, page 23).

3. On [redacted], a request for a power wheelchair for the Appellant was received by the MHP. The request was not accompanied by supporting medical documentation of a permanent and progressive condition or why she could not propel a manual wheelchair. In addition, the request noted that the Appellant had a power wheelchair. (Exhibit 1, page 23).

4. On [redacted], the MHP denied the request for a power wheelchair for the Appellant. The reason for denial was that the Appellant already has a power wheelchair and there was no documentation to support that the current wheelchair does not adequately meet the Appellant's needs. (Exhibit 1, pages 18-19).

5. On [redacted], the Appellant filed an internal grievance/appeal of the denial. (Exhibit 1, page 25).

6. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's Request for Administrative Hearing. (Exhibit 2, page 1).

7. On [redacted], the Appellant's internal grievance/appeal was denied. (Exhibit 1, pages 28-29)

8. On [redacted], the MHP received additional medical documentation from the Appellant's physician. (Exhibit 3)

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 MHPs.

The Respondent is one of those MHPs.

> 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. The Contractor 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 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.

(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Section 1.022(AA), Utilization Management, Contract, October 1, 2009.*

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual states:

> **[M]anual 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.
>
> * * *
>
> **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 put 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. Has a diagnosis/condition that indicates a lack of functional ambulatory status.

* * *

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**.

Department of Community Health,
Medicaid Provider Manual, Medical Supplier
Version Date: April 1, 2010, Pages 79-83

In this case, the Appellant's physician requested a power wheelchair on the Appellant's behalf. According to the certificate of medical necessity, the Appellant suffers from severe osteoarthritis, morbid obesity, and difficulty walking. The certificate stated that the Appellant can propel a manual wheelchair for 40-50 feet, she can ambulate without assistance for 10-20 feet, and she can ambulate with an assistive device for 20-30 feet. It further stated that the power wheelchair would be used inside the Appellant's home, not outside of it. (Exhibit 1, page 23). The Appellant's physician also provided the MHP with a report dated [redacted], which states that the Appellant "is more comfortable in a wheelchair than when ambulating with an assistive device." (Exhibit 3, page 12)

The Appellant testified that she did have a power scooter, which was donated to her, but its motor quit on [redacted], and she cannot find anyone to fix it. (Testimony of [redacted])

The Appellant further testified that some of the information in the certificate of medical necessity is incorrect. She stated that, contrary to the certificate, she did not use her power scooter in her home. She is able to walk in her home with a knee brace and a cane. She explained that she needs the power wheelchair for use outside of her home, i.e., to shop and run errands, because she is unable to walk for more than a block without resting. However, she also testified that she was able to march in place during a fitness class that she attended through the MHP.

The eligibility criteria for a power wheelchair are set forth above. A power wheelchair is one of many categories of wheelchairs that a beneficiary may qualify for. If a client does not meet the eligibility criteria for a standard wheelchair, he or she will not qualify for a power wheelchair. A power wheelchair is considered a type of wheelchair that the

beneficiary may qualify for if he or she requires a wheelchair for ambulation, and the standard wheelchair does not meet a beneficiary's particular functional needs.

In this case, the MHP properly denied the Appellant's request for a power wheelchair because she does not even meet the eligibility criteria for a standard wheelchair. The Appellant's own testimony establishes that she has functional ambulatory status. She testified that she is able to walk around her home with a cane and a brace. She further testified that she can walk outside of the home for a block. In addition, the medical documentation provided by the Appellant's physician states that she is "more comfortable" in a wheelchair than ambulating with an assistive device. It does not say that the Appellant is unable to ambulate with an assistive device.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/4/2010

***** 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.