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],

Docket No. 2010-54279 QHP
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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. [redacted] appeared as a witness for the Appellant. [redacted], represented [redacted], the Medicaid Health Plan (MHP). [redacted], appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a power scooter?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] female Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted].

2. On [redacted], the MHP received a request for a power scooter for the Appellant listing diagnoses of COPD and obesity. The attached physical therapy evaluation noted that the Appellant has had a circulatory problem in her legs for about [redacted] years, requiring multiple surgeries and with more involvement of the left leg, as well as compromised left knee stability. The evaluation indicated that the Appellant can ambulate 100 feet before she has to sit down due to pain, uses an electric scooter at times when she goes to the store, and would not be able to ambulate great distances. (Exhibit 1, page 9-14)

3. On [redacted], the MHP sent the Appellant a denial notice, stating that the request for a power scooter was denied based on the [redacted]. Specifically because the submitted documentation did

not show she was non-ambulatory or only able to transfer from bed to chair. (Exhibit 1, pages 2-3)

4. The Appellant requested a formal, administrative hearing contesting the denial on [redacted].

5. On [redacted], the Appellant's physician wrote a letter in support of her power scooter request describing additional diagnoses as well as descriptions of the Appellant's impairments with activities of daily living and what other alternatives have been tried to improve the Appellant's mobility.

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.

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services. An MHP must also provide its members with the same or similar services or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual. The DCH-MHP contract provisions also allow prior approval procedures for UM purposes.

Fee-for-service Medicaid beneficiaries have limited access to power scooters. The Medicaid Provider Manual policy requires prior authorization for all adult wheelchairs, power-operated vehicles, seating, and accessories. *Department of Community Health,* Medicaid Provider Manual, Medical Supplier, Version Date: July 1, 2010, Page 88. The standards of coverage for power scooters are set forth below:

> **Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings**
>
> May be covered if the beneficiary meets **all** of the following:
>
> - Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals.
> - Requires use of a wheelchair for at least four hours throughout the day.
> - Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate.
> - Has a cognitive, functional level that permits safe operation of a power mobility device with or without training.
> - Has visual acuity that permits safe operation of a power mobility device.
> - For a three-wheeled power mobility device, has sufficient trunk control and balance.
>
> *Department of Community Health,*
> *Medicaid Provider Manual, Medical Supplier*
> *Version Date: July 1, 2010, Page 83*

The MHP also requires prior approval for power scooters, and utilizes the [redacted] to review such requests. Regarding medical necessity, the [redacted] requires all of the following criteria to be met:

A. The Member has at least one of the following:

- He/she is totally non-ambulatory, *or*

- He/she can only bear weight to transfer from a bed to a wheelchair, *or*

- He/she has impaired mobility, combined with difficulty in performing mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing.

B. The member 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:

- Limitations of strength, endurance, range of motion, coordination and absence or deformity in one or both upper extremities, and trunk control and balance, should all be considered.

- Requires PT/Physiatry evaluation.

C. The member's condition is such that the requirement for a power wheelchair is long term (at least six months).

D. The member requires the use of a wheelchair for at least four hours throughout the day.

E. Must be able to be positioned in the chair safely and without aggravating any medical condition, or causing injury:

- Requires PT/OT evaluation.

F. The member's typical environment must support the use of electric, motorized, or powered wheelchair- factors such as adequate access, physical layout, maneuvering space, surfaces (thresholds more than 1 ½ inches), and obstacles, should all be considered:

- Requires evaluation by durable medical equipment (DME) supplier.

G. The member demonstrates the capability and the willingness to consistently operate the device safely without personal risk or risk to others:

- Requires PT/OT evaluation.

H. The member does not have any significant impairment of cognition, judgment, and/or vision that might prevent effective use of the wheelchair or reasonable completion of tasks with a wheelchair.

I. A specialist in physical medicine (PM&R) or neurology has provided an evaluation of the patient's medical and physical condition assuring that there is a medical necessity, and signed a prescription for the item. When such a specialist is not reasonable accessible, e.g., more than one (1) day round trip from the beneficiaries home or the patient's condition precludes such travel, an evaluation and prescription from the beneficiary's physician is acceptable.

Molina Healthcare of Michigan Utilization Guideline,
(Exhibit 1, pages 5-8)

The MHP determined that the documentation submitted with the Appellant's prior authorization request did not meet the criteria set forth in the [redacted]. Specifically, the information was insufficient to support criteria A, B, D, and F as listed above. (Medical Director Testimony) The physical therapy evaluation states that the Appellant can ambulate 100 feet, but not much information was provided on the Appellant's ability to propel a manual wheelchair or to support a need for use of a wheelchair four hours per day. Further, no environmental assessment was included. (Medical Director Testimony and Exhibit 1, pages 13-14)

The Appellant disagrees with the denial and testified she has had five surgeries on her legs. She stated that the power scooter would be used inside and outside her home. She indicated she has trouble walking every now and then and uses a cane in her home or a wheelchair occasionally. She described her home as a small apartment and explained that she sets down most of the time and does not go down the hallways to the laundry facilities. The Appellant testified that the medical supply company did complete an environmental assessment of her home, however, it is unclear why this was not submitted with the prior authorization request. The Appellant stated that she uses a wheelchair outside of her home, such as at her doctor's office.

The Appellant's son provided testimony that he assists the Appellant with cooking meals, shopping and various cleaning activities. He stated that if the Appellant tries to walk through a store, her legs will swell and she will have trouble moving the rest of the day. However, neither his testimony or the submitted Home Help Services provider logs document impairments with the mobility-related activities of daily living (MRADLs) listed in the [redacted], feeding, dressing, grooming, and bathing. (Exhibit 3)

While this ALJ sympathizes with the Appellant's situation, the documentation provided with the prior authorization request does not support that she has met all of the criteria required for prior approval of a power scooter through her MHP. The MHP's required criteria for approval of a power scooter are consistent with the Medicaid policy and are not designed to prevent coverage of a medically necessary service. Regarding criteria A, the evidence does not indicate that the Appellant is totally non-ambulatory or can only bear weight to transfer from a bed to a chair or wheelchair or that she has impaired mobility combined with difficulty performing MRADLs. Regarding criteria B, the submitted hand written notes are difficult to read, but do note that shortness of breath secondary to COPD, tendonitis in arms and generalized weakness prevent manual wheelchair use. (Exhibit 1, page 11) However, scant information was provided on next page regarding the respiratory and musculoskeletal findings. (Exhibit 1, page 12) Regarding criteria D, the evidence does not indicate how many hours throughout the day wheelchair use is required. Lastly, no environmental evaluation was submitted to satisfy criteria F. The [redacted], letter from the Appellant's physician provides additional information relevant to several of the [redacted], however, it was not available to the MHP when they reviewed the Appellant's prior authorization request in [redacted] and does not appear to provide documentation supporting that all of the criteria are met. Accordingly, the MHP's denial is upheld.

The Appellant may re-apply for prior approval at any time should she obtain additional supporting documentation.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/7/2010

***** 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.