**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. 2011-12214 QHP
Case No. 10495467

## 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], was present. Her friend, [redacted], represented her. The Medicaid Health Plan (MHP), [redacted], was represented by [redacted]. [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 scooter?

## 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, who is enrolled in the MHP.

2. The Appellant is [redacted] with a history of bunions, bi-lateral hip replacement, and osteoarthritis. (Exhibit 1, page 12; Testimony of [redacted])

3. On [redacted], a request for a power scooter for the Appellant was received by the MHP. The medical documentation submitted with the request did not support that the Appellant cannot walk or that she is unable to propel a manual wheelchair. (Exhibit 1, pages 12-13).

4. On [redacted], the MHP denied the request for a power scooter for the Appellant. The reason for denial was that there was no documentation to support that the Appellant cannot walk or that she is unable to propel a manual wheelchair. (Exhibit 1, pages 3-4).

5. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's Request for Administrative Hearing.

## 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:

**2.47 WHEELCHAIRS, PEDIATRICT MOBILTY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS**

* * *

## 2.47.B. STANDARDS OF COVERAGE

**Manual Wheelchair In Community Residential Setting**

May be covered if **all** of the following are met:

- Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute with or without an assistive medical device.

- 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.

- Purchase of a wheelchair is required for long-term use (greater than 10 months).

- 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.

    - The beneficiary has a willing, able, and reasonable caregiver to push the chair if needed.

* * *

**Power Wheelchair or Power Operated Vehicles (POV) in Both Community Residential and Institutional 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 1 ½", 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: October 1, 2010, Pages 81-83*

The MHP's policy requires that all of the following criteria be met before a power scooter can be approved as medically necessary:

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 bed to a chair or 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 the 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 reasonably accessible, e.g., more than one (1) day round trip from the beneficiary's home or the patient's condition precludes such travel, an evaluation and prescription from the beneficiary's physician is acceptable.

* * *

**Exclusion:**

1. MHM considers and electric, motorized, or powered wheelchair not medical necessary when any of the following conditions are present:

A. The wheelchair will be used only outside the home, or will be beneficial primarily in allowing the member to perform recreational activities, pursue employment, or for convenience.

*Molina Health Care of Michigan,*
*Utitlization Guideline,*
*Electric, Motorized or Powered Operated Vehicle*
*(Wheelchair or Scooter)*
(Exhibit 1, pages 8-9)

In this case, the Appellant suffers from bunions, bi-lateral hip replacement, and osteoarthritis. A physical therapy report indicated that the Appellant has difficulty with transferring, impaired balance, and difficulty walking. It further stated that she has a weak left shoulder and that a manual wheelchair is not used because of bi-lateral shoulder pain. However, the Appellant can ambulate with minimal assistance for 15 feet, and she can ambulate throughout her house with an assistive device—her walker. (Exhibit 1, pages 12-13, 16-18; Testimony of [redacted]) The Appellant testified that she can walk a city block with her walker, but she has to rest half way. She further stated that the power scooter would be used outside the Appellant's home, not inside of it. (Testimony of [redacted])

The eligibility criteria for a power scooter are set forth above. Here, the MHP properly denied the Appellant's request for a power scooter because she is able to ambulate with an assistive device. The Appellant testified that she is able to walk around her home with a walker. She further testified that she can walk outside of the home for a city block with her walker. In addition, the Appellant failed to provide clinical documentation to support why she cannot propel a manual wheelchair. And she testified that she intends to use the power scooter outside of her home—to catch the bus and shop—which precludes coverage under [redacted] policy. Accordingly, its denial in this case was proper. However, the Appellant may re-apply at any time.

**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 scooter.

**IT IS THEREFORE ORDERED** that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/11/2011

***** 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.