STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2011-32561 PA
Case No. [redacted]

Appellant
_____/

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], the Appellant, appeared on his own behalf. [redacted], Medicaid Utilization Analyst, represented the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a power wheelchair with accessories?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] year old Medicaid beneficiary who has been diagnosed with abnormality of gait, Pickwickian syndrome, and lymphedema. (Exhibit 1, page 10)

2. Department policy indicates wheelchair replacement is subject to manufacturer's warranty and/or cost of repairs and may also be considered when a significant change in the beneficiary's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of a wheelchair may be considered every 5 years for adults. Medicaid Provider Manual, Medical Supplier, 2.47.C, Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices, January 1, 2011, pages 89.

3. On [redacted], the Department approved a prior authorization request for a wheelchair for the Appellant. (Exhibit 1, page 38)

4. On [redacted], the Appellant was approved for a one time exception to the 5 year rule and a new wheelchair was authorized because he exceeded the weight capacity of the previously authorized wheelchair. (Medicaid Utilization Analyst Testimony and Exhibit 1, pages 25-29)

5. The Appellant had problems with the wheelchair approved [redacted] chair, and repairs were authorized by the Department. (Uncontested)

6. While this wheelchair was at the vendor for repairs, they went out of business and the Appellant's chair was never returned to him. (Appellant Testimony and Exhibit 1, page 17)

7. On [redacted], a prior authorization request was submitted to the Department for a new power wheelchair for the Appellant. (Exhibit 1, pages 10-24)

8. On [redacted], the Department denied the prior authorization request because the Department's records indicated that the Appellant had been provided this service within the last 5 years, specifically on [redacted], and policy indicates one wheelchair can be approved per 5 years. (Exhibit 1, pages 8-9)

9. On [redacted], the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (Exhibit 1, page 4)

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.

The pertinent parts of the Medicaid Provider Manual include:

> **1.5 MEDICAL NECESSITY**
>
> Medical devices are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.
>
> The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should

include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDCH standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.
- It is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order.
- It meets the standards of coverage published by MDCH.
- It meets the definition of Durable Medical Equipment (DME), as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

* * *

1.8 Durable Medical Equipment

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1.8.C. REPAIRS AND REPLACEMENT PARTS

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply loaner equipment while the beneficiary-owned item is being serviced at no charge to MDCH. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDCH will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDCH as a rental.

Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. The RB modifier is required.

For a repair in which no specific HCPCS code is appropriate, report HCPCS code E1340 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. The RB modifier is reported for the replacement part of the DME furnished as part of the repair.

PA is required. The provider must provide a manufacturer's invoice or other documentation that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDCH will consider replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section of this chapter apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.

MDCH will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through PA or items that would fall under the HCPCS code description to accommodate Medicaid fee screens.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-fabricated service in lieu of the availability of a code to cover a prefabricated item.

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS

2.47.A. DEFINITIONS

Wheelchair
A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc.

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Licensed/Certified Medical Professional
A licensed/certified medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier.

Medicaid policy requires that assessments must be performed by a licensed/certified medical professional. A physical therapy assistant (PTA) or a certified occupational therapy assistant (COTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.

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Institutional Residential Setting
An institutional residential setting refers to a nursing facility, hospital long-term care unit, or county medical care facility.

Community Residential Setting
A community residential setting is defined as a non-institutional setting in the community, i.e., beneficiary's own home, Adult Foster Care (AFC), Assisted Living or Group Home.

2.47.B. STANDARDS OF COVERAGE

* * *

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.

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Wheelchair Accessories

Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific wheelchair accessory codes when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or an addition to an existing wheelchair if:

- It is required to provide safety.
- It is required for appropriate positioning.
- It is the most economic alternative.

For additions to an existing wheelchair, the physician or the occupational or physical therapist must address the status/condition of the current wheelchair and include the brand, model, serial number, and age of the current wheelchair. If MDCH did not purchase the wheelchair being modified, all documentation requirements must be provided as if the request is for a new or initial wheelchair. Refer to

the Non-Covered Items section of this chapter for information on accessories that are not covered.

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2.47.C. PRIOR AUTHORIZATION FOR PURCHASE, RENTALS, REPAIRS, AND/OR REPLACEMENT OF MOBILITY DEVICES

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Rentals, Repairs and Replacement

A wheelchair can be considered a **capped rental** or a **purchase** item.

Repairs for beneficiary-owned mobility devices are covered only after the manufacturer's warranty has been exhausted. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. If repair of a wheelchair not purchased by MDCH is requested, the item must be medically necessary and meet the basic standards of coverage. The repair of a second (older) manual or power wheelchair used as a back-up wheelchair is not covered. Repair of a wheelchair involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement, and finishing.

Replacement of a mobility device is subject to the manufacturer's warranty and/or cost of repairs. The replacement may also be considered when a significant change in the beneficiary's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children.

MDCH Medicaid Provider Manual,
Medical Supplier Section
January 1, 2011, pages 4-5, 12-15, 81-83, 87 and 89.

In the present case, the Department denied the Appellant's [redacted], request for a new power wheelchair with accessories because a wheelchair had been authorized within the past five years. (Exhibit 1, pages 8-9) The Department's Medicaid Utilization Analyst explained that in [redacted] the Department approved a new wheelchair as a one time exception to the five year rule because the documentation submitted at that time showed that Appellant exceeded the weight capacity of the wheelchair previously authorized in [redacted]. The Medicaid Utilization Analyst testified that the documentation submitted in [redacted] did not indicate a significant change in the Appellant's condition or that there was an inability to restore the Appellant's current chair to serviceable condition. She further noted that the requested wheelchair did not appear to be wide enough to accommodate the Appellant's reported hip measurement. (Medicaid Utilization Analyst Testimony)

The Appellant disagrees with the denial and testified that the [redacted] prior authorization request was not submitted due to a medical issue. Rather, this prior authorization request was submitted because the vendor that was repairing the wheelchair authorized in [redacted] went out of business and never returned the wheelchair to the Appellant. He further indicated the hip measurement may not be accurate and he has requested to be re-measured to provide more accurate information to the Department. (Appellant Testimony)

It was uncontested that there were problems with the wheelchair authorized in [redacted] and the Department authorized repair services. The Medicaid Utilization Analyst testified that the Department would have needed documentation of the vendor closing and not returning the Appellant's wheelchair to consider the [redacted] request for a new wheelchair. While the hand written note is difficult to read, documentation of the loss of that wheelchair was included in the Mobility and Seating Evaluation and Justification submitted with the [redacted] prior authorization request. (Exhibit 1, page 17) After this note was specifically addressed during the hearing proceedings, the Medicaid Utilization Analyst testified that the Appellant's prior authorization request could be re-considered. She requested additional information including a clearer statement of what happened with the previously authorized wheelchair, a current evaluation (within 90 days) and new measurements for the Appellant to ensure the appropriateness of the requested power wheelchair. (Medicaid Utilization Analyst Testimony) The Appellant indicated he would provide this information to the Department. (Appellant Testimony)

Based on the documentation submitted, the Department improperly denied the Appellant's prior authorization request. The information submitted with the [redacted] prior authorization request did note that the vendor that was repairing the wheelchair authorized in [redacted] went out of business and this wheelchair was never returned to the Appellant. (Exhibit 1, page 17) Accordingly, the Department's determination to deny the Appellant's [redacted] request for a new power wheelchair is reversed and the Department shall re-consider the Appellant's prior

authorization request. If he has not already done so, the Appellant should submit the requested additional documentation to the Department.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly denied the Appellant's request for a new power wheelchair with accessories.

IT IS THEREFORE ORDERED that:

> The Department's decision is REVERSED. It is therefore ORDERED that the Department re-consider the Appellant's [redacted], prior authorization request.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/1/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.