STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

Docket No. 2012-23463 QHP

[redacted]

Appellant

[redacted]/

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], M[redacted], represented the Appellant. [redacted], the Appellant, appeared and testified. [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 an electric, motorized, power-operated vehicle (wheelchair/scooter)?

FINDINGS OF FACT

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

1. The Appellant is a [redacted]-year-old Medicaid beneficiary who was enrolled in the Respondent MHP, [redacted], until [redacted]

2. On [redacted], the MHP received a request for a powered scooter for the Appellant listing a diagnosis of COPD. (Exhibit 1, pages 12-24)

3. Submitted documentation included an [redacted] clinical note, which in part, states the Appellant was independent with activities of daily living (ADLs), ambulates with cane, denies falls, has a skilled nursing visit once per week, and complaints of decreased strength, endurance and significant activity intolerance. A [redacted] clinical note, in part, indicates that Appellant lives in a trailer with multistep entry, completes ADLs slowly with occasional assistance with dressing and standby

assistance for showering, is able to ambulate short distances in his home though difficulties were observed, has a history of falls, stated he is not going to use a wheeled walker when this was discussed, and notes left shoulder limitation. (Exhibit 1, pages 18 and 22)

4. On [redacted], the MHP sent the Appellant a denial notice, stating that the request for an electric, motorized, powered operated vehicle (wheelchair/scooter) was denied based on the [redacted] Utilization Guidelines. (Exhibit 1, pages 2-3)

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

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 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: October 1, 2011, Page 83. 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: October 1, 2011, Page 83*

The MHP also requires prior approval for power scooters, and utilizes the [redacted] Utilization Guideline to review such requests. Regarding medical necessity, [redacted] Utilization Guideline 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.

[redacted] *Utilization Guideline,* (Exhibit 1, pages 7-9)

The MHP's criteria are allowable under the contract as they do not effectively avoid providing medically necessary services and are consistent with the applicable Medicaid provider manuals and publications for coverages and limitations.

The MHP determined that the documentation submitted with the Appellant's prior authorization request did not meet the criteria set forth in the [redacted] Utilization Guidelines. Specifically, the denial notice and hearing summary note that the information submitted indicate the Appellant walks with a cane and refuses to use a wheeled walker, is independent in normal daily activities, lives in a trailer, and denied falls. (Exhibit 1, pages 1-2)

The Appellant disagrees with the denial. The Nurse Practitioner questioned where it was written that there are no falls. The quote of "denies falls" in the hearing summary and denial notice appears to come from the [redacted] clinical note. (Exhibit 1, page 18) The Nurse Practitioner's testimony that the Appellant has a history of falls is supported by the [redacted] clinical note. (Exhibit 1, page 22) However, it is not clear why the Appellant would have denied falls on [redacted] then reported 100 falls in the pas[redacted] months during the [redacted] visit. (Exhibit 1, pages 18 and 22)

The Nurse Practitioner testified that the Appellant has not refused to use a wheeled walker; rather he is unable due to chronic severe shoulder pain. This was not clear in the [redacted] clinical note submitted to the MHP, which documented shoulder limitations but also indicated the Appellant stated he would not use a wheeled walker. (Exhibit 1, page 22)

The Appellant and Nurse Practitioner credibly testified that when the Appellant walks even short distances in his home, he is slow and must take breaks. (Appellant and Nurse Practitioner Testimony) This was also documented in the [redacted] clinical note. (Exhibit 1, page 22) However, the documentation of the Appellant's ability to complete Activities of Daily Living (ADLs) was also inconsistent. The [redacted] clinical note indicates that Appellant is independent with ADLs. The [redacted] clinical notes indicate he completes the ADL of dressing independently but slowly most of the time and occasionally requires some assistance. He also receives stand by assistance with showering. (Exhibit 1, pages 18-22)

The Nurse Practitioner' also submitted a [redacted] letter supporting the Appellant's need for an electric mobility device. The letter indicates the Appellant can still complete activities of daily living independently, but very slowly and with difficulty due to severe activity intolerance, limited endurance and dyspnea with minimal exertion. The Nurse Practitioner also addresses the Appellant's inability to use a walker and his left shoulder impairment and notes the Appellant's sons are willing to build a ramp for the Appellant's home. (Exhibit 2) However, this information was not provided until after the Appellant's enrollment with the MHP ended.

While this ALJ sympathizes with the Appellant's situation, the documentation provided with the prior authorization request was not consistent to support that the Appellant met all of the criteria required for prior approval of a power mobility device through the MHP. Accordingly, the MHP's denial must be upheld based on the documentation submitted with the prior authorization request. The Appellant was no longer enrolled in the MHP when additional information was provided, and was without insurance at the time of the [redacted] hearing proceedings. If the Appellant becomes eligible for Medicaid coverage again in the future, he can have a new prior authorization request for a power mobility device submitted with supporting documentation to the Department or whichever MHP he may be enrolled with.

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 an electric, motorized, powered operated vehicle (wheelchair/scooter).

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 3-20-12

***** 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.