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:

Docket No. 2012-35556 PA

[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], father, appeared on the Appellant's behalf. [redacted], RN, Medicaid Utilization Analyst represented the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a stroller style manual wheelchair?

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 cerebral palsy and seizures. (Exhibit 1, pages 1-2)

2. On [redacted] the Department received a prior approval-request for a stroller style manual wheelchair. The included Mobility and Seating Evaluation and Justification that was completed [redacted] (Exhibit 1, pages 1-14)

3. On [redacted] the Department denied the prior authorization request because the standards of coverage were not met based on the documentation provided. (Exhibit 1, pages 16-17)

4. On [redacted] the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (Exhibit 1, page 18)

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 Medicaid Provider Manual provides, in pertinent part, as follows:

> **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.

* * *

1.5.C. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

***

1.7.G Age Parameters

Some services are only covered if the beneficiary is under the age of 21. For specifics regarding PA requirements and coverage, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter.

***

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.

Pediatric Mobility Product
Pediatric mobility products are pediatric-sized mobility and positioning medical devices (as defined by PDAC) that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems designed specifically for children with special needs. These products must meet the definition of Durable Medical Equipment (DME) (refer to the Program Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative.

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.

Pediatric Subspecialist
A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.

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

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

In addition:

A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required.

A **standard light-weight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance.

A **heavy-duty standard wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds.

An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds.

A **high-strength light-weight or ultra-light standard wheelchair** may be covered when required for a specific functional need.

A **back-up or secondary standard manual wheelchair** may be considered when:

- The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living.
- The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.

***

Pediatric Mobility Devices and Wheelchairs

May be covered if **all** of the following are met for each type of device. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDCH also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

For manual pediatric wheelchairs:

- Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without an assistive medical device or has a willing and able caregiver to push the chair **and** the wheelchair is required in a community residential setting.
- Is required for long-term use (greater than 10 months).
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.
- Is designed to be transportable.
- Is the most economic alternative available to meet the beneficiary's mobility needs.

For power wheelchairs:

- 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 (this includes the need to rest at intervals).
- Is able to safely control the wheelchair through doorways and over thresholds up to 1½".

- Has a cognitive, functional level that is adequate for power wheelchair mobility.
- Has visual acuity that permits safe operation of a power mobility device.
- Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width.
- For a three-wheeled power mobility device, has sufficient trunk control and balance.

For transport mobility medical devices (e.g., strollers):

- Is over three years of age or has a medical condition that cannot be accommodated by commercial products.
- Will be the primary mobility device due to inability to self-propel a manual wheelchair or operate a power wheelchair.
- Is required as a transport device when the primary wheelchair cannot be designed to be transportable.
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.
- Is the most economic alternative available to meet the beneficiary's mobility needs.
- Is required for use in the community residential setting.

***

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

Prior Authorization

The Medicaid Utilization Analyst (Program Review Division) is the authorized Medicaid representative who determines if the service requested falls within the standards of coverage. A prior authorization request may be returned or denied if the documentation is incomplete and not specific to the beneficiary and device requested.

MDCH reserves the right to request additional documentation to determine medical necessity. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDCH also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

For beneficiaries in the community residential setting, the decision notice is sent to the medical supplier with a copy to the beneficiary.

For beneficiaries in the institutional residential setting, the decision notice is sent to the institutional residence with a copy to the beneficiary.

Prior authorization is required for:

- All adult wheelchairs, power-operated vehicles, seating, and accessories.
- Rental of a standard wheelchair beyond three months for hospital discharge waiver.
- New and replacement custom-fabricated seating systems, and the addition of functions for tilt-in-space and/or recline (power or manual).
- Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items.
- Replacement of standard wheelchairs beyond established timeframes.

Clinical Documentation
The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the form is completed.

For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDCH also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

MDCH Medicaid Provider Manual,
Medical Supplier Section
October 1, 2011, pages 4-88.

The Medicaid Utilization Analyst explained that the Department denied the Appellant's [redacted] prior authorization request for a stroller style manual wheelchair because the documentation submitted was insufficient to meet the standards of coverage. The [redacted] submission included a Mobility and Seating Evaluation and Justification that was completed [redacted] The above cited policy regarding clinical documentation requires the evaluation to be submitted within 90 days. The Medicaid Utilization Analyst also noted that the [redacted] version of the MSA-1656 was utilized rather than the current version of the form. Changes were made to the form to help ensure the needed information is provided to review prior authorization requests. (Medicaid Utilization Analyst Testimony)

In her testimony, the Medicaid Utilization Analyst also went over many specific areas were additional information is needed to support the Appellant's for a wheelchair. For

example, the submitted documentation did not establish the ability to accommodate growth and adjustments as required for pediatric mobility devices and wheelchairs.

The Appellant's father's agreed that additional information needed to be provided. (Father Testimony) The Medicaid Utilization Analyst stated she would send a copy of the current version of the MSA-1656 Mobility and Seating Evaluation and Justification from to the Appellant's father to facilitate submitting a new request with current documentation.

The Department's denial must be upheld because the submitted documentation did not meet the Medicaid standards of coverage for stroller style manual wheelchair and the MSA-1656 Mobility and Seating Evaluation and Justification was not completed within 90 days of the prior authorization request.

As noted during the hearing proceedings the Appellant can have another prior authorization request for a wheelchair or mobility product submitted at any time with current supporting documentation.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for a stroller style manual wheelchair based on the documentation that was submitted to the Department.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 5-29-12

***** 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.