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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2013-10330 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]. [redacted], mother, represented the Appellant. Radiance DuPree, the Appellant, was present. Sam DuPree, father, appeared as a witness for the Appellant. Elizabeth Bennani, Medicaid Utilization Analyst, represented the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a replacement manual wheelchair and 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 nonteratogenic anomalies, immobility syndrome, and joint contracture. (Exhibit 1, page 10)

2. On or about [redacted], the Department approved a prior authorization request for a manual wheelchair with accessories for the Appellant. (Exhibit 1, page 29)

3. On or about [redacted], the Department received a prior approval-request for a replacement manual wheelchair and accessories for the Appellant. Additional medical documentation was attached. (Exhibit 1, pages 10-28)

4. On [redacted], the Department determined the prior authorization

request should be denied because policy allows for a wheelchair to be considered for replacement every five years and the Appellant has two wheelchairs, a power and a manual, that are less than five years old. (Exhibit 1, page 10)

5. On [redacted], the Department issued a Notification of Denial to the Appellant. The Department indicated the replacement manual wheelchair and accessories were denied. (Exhibit 1, pages 8-9)

6. On [redacted], the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (Exhibit 1, pages 6-7)

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:

> **1.3 PLACE OF SERVICE**
>
> Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in the beneficiary's place of residence except for skilled nursing or nursing facilities.
>
> * * *
>
> **1.5 MEDICAL NECESSITY [CHANGES MADE 7/1/12]**
>
> 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:

- The service/device meets applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, 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.
- The function of the service/device:
    - meets accepted medical standards;
    - practices guidelines related to type, frequency, and duration of treatment; and
    - is within scope of current medical practice.
- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device 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.
- The service/device meets the standards of coverage published by MDCH. **(revised 7/1/12)**
- 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).

* * *

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.

Manual Wheelchair with Custom- Fabricated Seating System in both Community Residential and Institutional Residential Settings

May be covered if **all** of the following are met, in addition to the Standards of Coverage listed under Manual Wheelchair in Community Residential Setting:

- Medical documentation provides a clinical assessment of the specific functional/clinical need for a custom-fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage.

- Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width.
- Is an integral part of the care regimen in the community residential setting or the daily nursing plan of care in an institutional residential setting.

* * *

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 economical 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.

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
July 1, 2012, pages 3-6 and 81-86

In the present case, the Department approved a prior authorization request for a manual wheelchair with accessories for the Appellant on or about [redacted]. (Exhibit 1, page 29) The Department received a prior authorization request for a replacement manual wheelchair for the Appellant on or about [redacted]. (Exhibit 1, pages 10-28) The Department determined the prior authorization request should be denied because policy allows for a wheelchair to be considered for replacement every five years and the Appellant has two wheelchairs, a power and a manual, that are less than five years old. (Exhibit 1, pages 8-10)

The Medical Analyst explained that under the above cited Medicaid Provider Manual Policy, replacement is subject to the manufacturer's warranty and/or the cost of repairs. Replacement may also be considered when a significant change in the beneficiary's condition has occurred or the item can not be restored to a serviceable condition. The Department has not received any request for repairs of the current manual wheelchair. Further, the information submitted with the [redacted] request did not document a significant change in the Appellant's condition had occurred, such as growth or physical abilities. The Department did look at the last prior authorization request to see if there had been changes. The information submitted with for the manual wheelchair that was approved in [redacted] indicated the Appellant's height as [redacted] inches and weight as [redacted] pounds. The [redacted] information with the [redacted] prior authorization request indicates the Appellant's height is [redacted] inches and her weight is [redacted] pounds. This would be an increase of one inch in height and fifteen pounds is weight. Regarding the problems noted in the request for hearing about the arm rests and foot pedals, replacement of these parts can be done without prior authorization. (Medicaid Utilization Analyst Testimony)

The Appellant's mother disagrees with the denial and testified there has been a significant weight gain and growth. The Appellant has outgrown the current manual wheelchair, which is also worn. The Appellant's feet protrude out over the foot pedals and the arm rests are worn. The current manual wheelchair is not good for the Appellant's posture. The padding on the chair is worn and can not be taken off to be washed or adjusted. The Appellant uses the manual wheelchair daily in place of the motorized chair because they do not currently have a van to accommodate the motorized chair. This is a small wheelchair that can not be adjusted to accommodate the Appellant's growth or weight gain. Accordingly, the Appellant's mother is concerned about how the current manual wheelchair could be repaired because the Appellant has outgrown the chair. (Mother Testimony)

The Medical Analyst testified that the upholstery can also be replaced without prior authorization, in addition to the arm rests and foot pedals. Accordingly, the remaining issue is whether the current chair is big enough for the Appellant. In reviewing the information provided with this prior authorization request, the current manual wheelchair is 16 inches in width and 16 inches in depth. (Exhibit 1, page 14) The current measurements show the Appellant is 16 inches at the hips and has a seat depth of 17 inches. (Exhibit 1, page 15) Typically, two inches are subtracted from the seat depth

measurement to get the correct seat depth size. Accordingly, if the Appellant grows an inch anywhere she could not use the current wheelchair. (Medicaid Utilization Analyst Testimony)

Based on the documentation submitted, the Appellant did not meet the Medicaid standards of coverage for the requested replacement manual wheelchair and related accessories. The current manual wheelchair is less than five years old and the documentation submitted did not support medical necessity for a replacement manual wheelchair. There has been no request for repairs, documentation that repairs would be more costly than replacement, or that repairs could not make the current wheelchair serviceable for the Appellant. The worn parts noted by the Appellant's mother can be replaced without prior authorization. The documented measurements of the Appellant and the current manual wheelchair indicate she is at the limit, but has not yet exceeded the size of the current wheelchair. Accordingly, the Department's denial must be upheld based on the available information.

As noted during the telephone hearing proceedings, a new request for a replacement manual wheelchair can be submitted with additional 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 replacement manual wheelchair and accessories based on the submitted documentation.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s\
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/18/2013

***** 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.