STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Docket No. 2013-10346 QHP
Case No. [redacted]

Appellant
_____/

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]. [redacted], the Appellant, appeared on his own behalf. [redacted], [redacted] Health System, Orthopedics Department, appeared as a witness for the Appellant. [redacted], Inquiry Dispute Appeals Resolution Coordinator, represented [redacted] of Michigan, the Medicaid Health Plan (MHP). [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a power scooter?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary who is enrolled in the Respondent MHP, Molina Healthcare of Michigan.

2. On [redacted], the MHP received a request for a powered scooter for the Appellant listing a diagnosis of intervertebral disc disorder with myelopathy to lumbar region. Additional medical documentation was included. (Exhibit 1, pages 8-18)

3. The [redacted] Specialty Evaluation Report indicates the Appellant has the ability to ambulate approximately 300 feet with the assistance of his cane and is independent will all his ADLs and mobility needs. This report also states the power operated vehicle, or scooter, is essential for the Appellant to complete his ADLs as well as housekeeping and meal preparation. It was noted that it would be used outdoors and within the

community to do shopping, attend doctor appointments and social activities. (Exhibit 1, pages 10-12)

4. The additional documentation indicates the Appellant has several other impairments, including spondylosis, stenosis and injury to both shoulders. (Exhibit 1, pages 13-18)

5. A [redacted] office note indicates the Appellant was being seen for his right shoulder and was doing a bit better with some of the exercise he is doing. It was noted that the Appellant just bought a home gym. Additionally, it was also noted that he was using a chain saw just a couple of days ago and felt the pop in his shoulder. (Exhibit 1, page 17)

6. On [redacted], the MHP sent the Appellant a denial notice, stating that the request for a power scooter was denied based on the Michigan Department of Community Health 2.47 criteria. The denial notice also listed the [redacted] of Michigan Utilization Guideline for Electric, Motorized, Powered Operated Vehicle (wheelchair/scooter). The notice states that after reviewing the clinical information provided, the power wheelchair criteria were not met; there was no evidence of the Appellant being non-ambulatory or only able to transfer from bed-to chair. (Exhibit 1, pages 19-22)

7. 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 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 (MPM) states:

> **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.
>
> ***
>
> **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: July 1, 2012, Pages 81-82

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviews prior approval requests under Molina Healthcare of Michigan Utilization Guideline. In part, it is required that all of the following criteria 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.

Molina Healthcare of Michigan Utilization Guideline,
(Exhibit 1, pages 4-7)

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.

Regarding the MDCH Medicaid Provider Manual Policy, the Medical Director noted that for even a manual wheelchair, the individual must have a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute or without an assistive medical device. The documentation submitted with the Appellant's prior authorization request indicates he can walk 300 feet with his cane. (Exhibit 1, pages 2 and 10, Medical Director Testimony) The Medical Director also noted that the submitted documentation did not address other criteria for a power wheelchair, such as the inability to operate a manual wheelchair for 60 feet or whether the Appellant would be spending at least four hours per day in the scooter. (Medical Director Testimony) The MHP determined that the documentation submitted with the Appellant's prior authorization request did not meet the criteria set forth in either the MDCH Medicaid Provider Manual Policy or the Molina Healthcare of Michigan Utilization Guideline. (Exhibit 1, page 19)

The Appellant disagrees with the denial and indicated that the information provided to the MHP was incomplete and/or inaccurate. The Appellant explained that the physical therapist did not watch him walk 300 feet from is car back to rehab. Rather, the Appellant walked from his car to the waiting area and sat down for 20 minutes, in pain. Then, he followed the lady who brought him back to the room, leaning on the door/wall on his way. The Appellant testified he was never able to walk 300 feet. Similarly, regarding the doctor's note that indicates he was using a chain saw, the Appellant explained that he was not out in the woods cutting lumber. Rather, he was using a little plug-in saw on a small stump just outside his back door and from a seated position. The Appellant described unbelievable pain he has and the history of his impairments. (Appellant Testimony)

The Appellant's doctor testified that the Appellant has advanced narrowing of the spine, which limits the function of his lower extremities. The Appellant has a hard time standing or walking for a long time and assistance with transportation is essential. He is also being treated by another doctor for rotator cuff tear, and the previous surgery for this was not terribly effective. A shoulder problem produces even more challenges and difficulties with transportation and level of function. Additionally, the doctor noted that that how the Appellant's condition affects his mobility would vary from day to day. (Doctor Testimony)

While this ALJ sympathizes with the Appellant's situation, the documentation submitted to the MHP with the prior authorization request was not consistent regarding his abilities and did not support that the Appellant met all of the criteria required for prior approval of a power mobility device through the MHP. Rather, it noted he could ambulate 300 feet with his cane, and did not specifically address criteria like the ability to operate a manual wheelchair or how long he would spend in the power scooter each day. Further, the submitted information was inconsistent by stating the Appellant was independent with all ADLs and mobility needs and also that it was essential for him to have the power scooter to complete ADLs. The documented information about using a chain saw, as written, also did not support the medical necessity of a power scooter for the Appellant. Accordingly, the MHP's denial must be upheld based on the documentation submitted with the prior authorization request.

The Appellant may wish to have a new prior authorization request for a power mobility device submitted to MHP with additional supporting documentation clarifying his impairments, abilities and medical needs for a power scooter.

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 a power scooter.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 1/23/2013

***** 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.