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:

Docket No. 2013-17008 PA

[redacted],

Appellant

[redacted]/

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], Case Manager, represented the Appellant. [redacted], the Appellant, appeared and testified. [redacted], appeared as a witness for the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], Medicaid Utilization Analyst, appeared as a witness for 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 with multiple diagnoses including spinal muscular atrophy, bronchomalacia, dysphagia, scoliosis, werdnig hoffman type II, chronic respiratory failure, and obstructive sleep apnea. (Exhibit 1, pages 7 and 9)

2. On or about [redacted], the Department received a prior approval-request for a power wheelchair with accessories for the Appellant. (Exhibit 1, pages 10-29)

3. On [redacted], the Department determined the prior authorization request should be denied. (Exhibit 1, page 9)

4. On [redacted], the Department issued a Notification of Denial to

the Appellant. The Department indicated the requested cup holder was non-covered. The Department further indicated the documentation submitted does not support the need for a seat elevator. (Exhibit 1, pages 31-32)

5. On [redacted], the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (Exhibit 1, pages 4-8)

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:

> **SECTION 1 – PROGRAM OVERVIEW**
>
> This chapter applies to Medical Suppliers/Durable Medical Equipment and Orthotists/Prosthetists.
>
> Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. (Refer to the General Information for Providers chapter for additional information.)
>
> The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.
>
> The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.
>
> This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and MDCH includes both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics.

* * *

1.3 PLACE OF SERVICE [CHANGES MADE 10/1/12]

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

* * *

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.

* * *

Standard Seating System in Community Residential Setting

May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties.

May be covered if all of the following are met:

- Two or more of the above clinical indications are documented in the medical record and in the mobility assessment.
- Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width.
- Must document the reason for the selection when the system cannot be used in more than one mobility device.
- Is the most economical alternative available to meet the beneficiary's mobility needs.

For CSHCS pediatric beneficiaries, a written order 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 written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

Custom-Fabricated Seating Systems

May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. May be covered if all of the following are met:

- Two or more of the above clinical indications are documented in the medical record and in the mobility assessment, and the severity of the clinical indications cannot be accommodated by a standard seating system.
- Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width.
- Must document the reason for the selection when the system cannot be used in more than one mobility device.
- Is the most economical alternative available to meet the beneficiary's mobility needs.

For CSHCS pediatric beneficiaries, a written order 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 written order from

an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

Manual or Power Recline Feature
May be covered when needed for relief of pressure on the seat and/or back, and **one** of the following applies:

- History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques).
- Has ability to tolerate a 90-135 degree range of motion at the hip, needed for reclining without triggering excessive abnormal tone.
- Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved.

A low shear recline back is covered when the beneficiary does not have the ability to reposition themselves in the wheelchair following reclining and the shearing would result in skin breakdown.

Manual Tilt-in-Space or Recline Function in Community Residential Setting

Manual tilt-in-space function allows the seat and back of the wheelchair to move as a unit, such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually.

The **tilt-in-space** function for a wheelchair may be covered if **one or more** of the following apply:

- History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques).
- Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective. State reason why changing angles of position is medically necessary.

- Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies.
- Beneficiary has knee contractures and a custom-molded seating system.

Coverage of both a **manual tilt-in-space and recline function** for a wheelchair requires medical need (such as high probability of the development of hip contractures) if only a tilt-in-space without recline is used. Also, there is a medical contraindication to using recline-only without the tilt-in-space function.

Power Tilt-in-Space or Recline Function in Both Community Residential and Institutional Residential Settings

Power tilt-in-space or recline function may be covered if **all** of the following exist:

- An existing medical condition results in the inability to reposition self without the use of a power tilt or recline mechanism.
- The frequency of repositioning is clinically indicated and is an integral part of the nursing facility plan of care.
- Beneficiary requires assistance to use a manual tilt-in-space or recline system, and there are regular periods of time that the beneficiary is without assistance.
- Beneficiary requires assistance to use a manual tilt-in-space or recline system, and is able to independently care for himself when provided a power tilt-in-space or recline modification.

For CSHCS pediatric beneficiaries, a written order 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 written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

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
October 1, 2012, pages 1, 3-6 and 80-86

Additionally, the Medicaid Provider Manual policy indicates some items are non covered. The list of items that are non covered induces, but is not limited to: adaptive equipment; equipment for social or recreational purposes; and Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.). MDCH Medicaid Provider Manual, Medical Supplier Section, October 1, 2012, pages 17-18.

In the present case, the Department does not contest that the Appellant meets the criteria for a new power wheelchair. (Medicaid Utilization Analyst Testimony) The Department determined that the Appellant's prior authorization request for this power wheelchair with accessories should be denied because the submitted documentation does not support the medical need for the seat elevator. The notice further indicted the requested cup holder is not covered. (Exhibit 1, page 31)

The Medicaid Utilization Analyst explained that many of the requested features would be approved, including tilt and recline functions, power articulating legs rest, the

expanded electronics for more than two power features, and the special ergonomic back. However, medical necessity for the seat elevator was not supported. The documentation submitted indicates the Appellant has a caregiver, and specified "24/7 with his nursing staff." (Exhibit 1, page 12) The submitted documentation further indicated the Appellant is dependant for transferring, is lifted by his nurses and has an old hoyer. (Exhibit 1, apge 13) The Department also considered the documentation regarding the Appellant's limitations with his upper extremities. (Exhibit 1, page 17) The Letter of Medical Necessity indicates the seat elevator was requested to allow the Appellant to transfer more readily in a downhill direction requiring less effort from the Appellant and his caregivers. (Exhibit 1, page 7) The Medicaid Utilization Analyst stated that with a caregiver present 24 hours a day and the current hoyer lift, utilizing the hoyer lift for transfers would be the safest and most cost efficient way to transfer. Further, the issues regarding access to reach objects and surfaces at home, school or in the community to improve independence and social interaction are not considered medically necessary. Further, the Appellant could select a different model power wheelchair that is not as low to improve accessibility in his apartment. (Medicaid Utilization Analyst Testimony)

The Appellant's Case Manager asserted that the seat elevator is necessary for the Appellant's quality of life, the Appellant's safety and the safety of his caregivers. With the seat elevator in his current power wheelchair, the Appellant is able to turn lights switches on/off, feed himself, and can complete his own oral care. The Appellant has wheelchair access to his apartment, but the apartment itself is not wheelchair accessible. The seat elevator allows the Appellant to be as independent as possible. The Appellant's Case Manager questioned how the hoyer was proven to be the safest for transferring the Appellant. The Appellant has a floppy neck, so utilizing the hoyer tends to cut of his airway during transfers. It is an older model manual hoyer, and there is no head support on the sling. While the Appellant has caregivers 24 hours a day, they are there for the tracheotomy and ventilator needs, not because of the Appellant's lack of independence. (Case Manager Testimony)

The LPN is concerned that the Appellant's quality of life would be negatively impacted without the seat elevator. Being able to be at the correct height for his table and computer allows the Appellant to complete most activities of daily living tasks on his own. Being able to turn a light switch or remove his dentures and place them in the sink after a meal may not be medical necessities but there are dignity and respect issues. The Appellant cares for himself as much as possible, and would not be able to continue the same level of living without the seat elevator. Further, the seat elevator on the current power wheelchair does assist with transfers, for example between the bed and the wheelchair. (LPN Testimony)

The Appellant stated that requested power wheelchair is about six inches lower than his current power wheelchair. Without a seat elevator it would be difficult for the Appellant to reach the table to eat, use a light switch, open the door, check his mail, etc. It would be difficult to find a new lower table at an appropriate height for he requested power

wheelchair if it does not have the seat elevator. The requested chair is able to go over three inch curbs, which is not possible in many of the other wheelchairs considered. (Appellant Testimony)

The Medicaid Utilization Analyst testified that adjustments can be made to some hoyer lifts and many types of slings are available. If the current hoyer is not meeting the Appellant's needs, a new hoyer lift can be requested with supporting documentation. A new manual hoyer would be more economic as they cost around [redacted]. (Medicaid Utilization Analyst Testimony) The listed charge for the seat elevator was [redacted]. (Exhibit 1, page 9)

It is clear that the Appellant's quality of life benefits greatly from the seat elevator. However, this ALJ has no equitable or constitutional authority and must review the Department's determination under the Medicaid Provider Manual policy. Based on the documentation submitted, the Appellant did not meet the Medicaid standards of coverage for the requested power wheelchair with accessories. The quality of life issues are clear, however, they are separate from medical necessity. Similarly, the primary reason the Appellant has caregivers 24 hours a day relates to his respiratory needs, but these caregivers are present and do assist the Appellant with transferring. The Medicaid Provider Manual policy only allows for coverage of the least costly alternative, and the information provided was not sufficient to support medical necessity for the requested seat elevator. Accordingly, the Department's denial of this power wheelchair and accessories must be upheld based on the available information.

If they have not already done so, a new request for a power 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 power wheelchair with 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

[redacted]
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Decision and Order

cc: [redacted]

Date Mailed: 03/01/2013

***** 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.