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. 2013-35629 QHP

[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] Grandmother and Guardian, represented the Appellant.

[redacted] was represented by [redacted] Manager of [redacted] is a Department of Community Health contracted Medicaid Health Plan ("MHP").

ISSUE

Did the MHP properly deny the Appellant's request for a McClaren Major Stroller?

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] ([redacted]) year old Medicaid beneficiary. (Exhibit 1, page 18)

2. On or about [redacted] the MHP received a request for a McClaren Major Stroller for the Appellant listing a diagnosis of cerebral palsy. (Exhibit 1, pages 16-24)

3. On [redacted] the MHP issued a letter to the Appellant indicating the prior authorization request was denied based on the information provided. The letter stated coverage is for standard durable medical equipment only and equipment that is not conventional or not medically/clinically necessary or for the convenience of the member or

caregivers will not be covered. Further, the letter stated the requested McClaren Major Stroller was determined to be non-standard medical equipment. (Exhibit 1, pages 25-26)

4. On or about [redacted] the Appellant's request for hearing was received by the Michigan Administrative Hearing System.

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 Medicaid Health Plans.

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. 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.
>
> Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:
>
> - Ambulance and other emergency medical transportation
> - Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy

- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services

- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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.

....

Contract, *Supra,* p. 49

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 sections of the Michigan Medicaid Provider Manual (MPM) state:

> **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 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.
>
> Medicaid Provider Manual, Medical Supplier Chapter
> January 1, 2013, Pages 84-85

The MHP's documentation and the testimony of the Director of [redacted] and the indicate that the MHP only covers standard durable medical equipment and equipment that is not conventional or not medically/clinically necessary or for the convenience of the member or caregivers will not be covered. The MHP acknowledged that the Appellant would meet the criteria for coverage of a standard durable medical equipment stroller. However, the MHP determined the requested McLaren Major

Stroller was non-standard medical equipment. It appears this was based on the finding that the McClaren Major Stroller is a commercially available product, rather than durable medical equipment. Further, in an [redacted] telephone conversation with a MHP Field Services Representative, the Appellant's grandmother acknowledged that this stroller was being requested for her convenience and the Appellant has the ability to ambulate. (Exhibit 1; Director of Medicaid Products Testimony)

The Appellant's grandmother disagrees with the denial and testified that they tried several strollers at the evaluation and some were way over the top with options the Appellant does not need. The Appellant's grandmother stated that the doctor who provided information for the prior authorization request had only seen the Appellant one. The neurologist who wrote the [redacted] letter has had more experience with the Appellant. The Appellant's grandmother also clarified that the Appellant cannot walk distances, is weak on his left side, has a loping gait, and falls a lot. The Appellant weights a little over [redacted] pounds so it is hard for her to carry him, and she wants to be able to do more with him. The umbrella stroller the Appellant has is not working for him anymore. (Grandmother Testimony)

The MHP provided sufficient evidence that its denial was consistent with Medicaid policy and allowable under the DCH-MHP contract provisions based on the information submitted with the [redacted] prior authorization request. Since the requested McLaren Major Stroller is a commercially available product, it cannot be covered as durable medical equipment. Accordingly, the MHP's determination must be upheld.

As discussed during the telephone hearing proceedings, at any time the Appellant can have a new prior authorization request submitted to the MHP for a stroller that is standard durable medical equipment with additional documentation supporting the medical necessity of the requested product, which should include documentation that no commercially available products can accommodate the Appellant's condition.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for McClaren Major Stroller based upon the available information.

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

Date Signed: [redacted]
Date Mailed: [redacted]

CL/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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.