

**STATE OF MICHIGAN  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant

\_\_\_\_\_ /

Docket No. 2011-12217 QHP  
Case No. ██████████

**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 ██████████. The Appellant was represented by her guardian/daughter, ██████████.

██████████ was represented by ██████████, ██████████. ██████████, ██████████, appeared as a witness for ██████████. ██████████ is a Department of Community Health contracted Medicaid Health Plan.

**ISSUE**

Did the Medicaid Health Plan properly deny the Appellant's request for a lift chair?

**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 ██████ year old Medicaid beneficiary who is enrolled in ██████████; a Department of Community Health contracted Medicaid Health Plan (MHP).
2. The Appellant has been diagnosed with hemiplegia and hemiparesis. (Exhibit 1, page 11)
3. On ██████████, a request for a lift chair was submitted to the MHP by the Appellant's provider. (Exhibit 1, pages 11 and 14-15)

4. On ██████████, the MHP sent a letter to the Appellant stating that the provider's request for a lift chair was denied because a lift chair is not a covered benefit. (Exhibit 1, pages 2-5)
5. The Appellant requested a formal, administrative hearing contesting the denial on ██████████.

### **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 Medicaid Health Plans.

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. Contractors 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 1-Z.

*Article II-G, Scope of Comprehensive Benefit Package.  
MDCH contract (Contract) with the Medicaid Health Plans,  
September 30, 2004.*

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**Decision and Order**

The major components of the Contractor's utilization management plan 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 Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

*Article II-P, Utilization Management, Contract,  
September 30, 2004.*

Section 1.10 of the Medical Supplier portion of the Medicaid Provider Manual, as effective October 1, 2010, addresses "Noncovered Items." Lift chairs, reclining chairs, and vibrating chairs are included in the list of items that are not covered by Medicaid. *Medicaid Provider Manual, Medical Supplier Section, October 1, 2010, Pages 16-17.* (Exhibit 1, pages 9-10)

On [REDACTED], the Appellant's provider submitted a request for a lift chair. (Exhibit 1, pages 11 and 14-15) A Medical Director for the MHP reviewed and denied the request because lift chairs are not a covered benefit under the Medicaid policy. (Medicaid Director Testimony and Exhibit 1, pages 9-10)

The Appellant's representative disagrees with the denial. The Appellant's representative testified that she understands Medicaid policy does not allow for coverage, but her mother really needs the chair.

