

**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. 2013-50521 PA
Case No. ██████████

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 ██████████. The Appellant was represented by ██████████. She had no witnesses. The Department was represented by Appeals Review Officer, ██████████. Her witness was Medicaid analyst, ██████████.

ISSUE

Did the Department properly deny Appellant's request for prior authorization?

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. (Appellant's Exhibit 1)
2. The Appellant is afflicted with quad cerebral palsy, spastic. (Department's Exhibit A, pp. 10 and 21)
3. The Appellant has need for a manner of stopping his elbows from going behind his back while utilizing his tray on his wheelchair. (Appellant's Exhibit I and See Testimony)
4. On ██████████, the Department received the request for an elbow stop and mounting bracket from ██████████, along with a letter of medical necessity from the supplier following the Department's request for additional information on receipt of PA. (Department's Exhibit A, pp. 10 through 18)

5. That information was reviewed by the PRD and denied on ██████████. (Department's Exhibit A, pp. 6 through 12)
6. The Department representative said the PA was denied chiefly because of a lack of medical necessity and cost effectiveness. (See Testimony of ██████████ and Department's Exhibit A, pp. 6 and 7)
7. The Appellant's representative said that the Appellant's request for elbow stops was a safety issue – as a means of preventing the Appellant from throwing his arms behind his back – sustaining injury. (See Testimony)
8. The instant request for hearing was received by the Michigan Administrative Hearing System (MAHS) for the Department of Community Health on ██████████. (Appellant's Exhibit 1)

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.

It is axiomatic that the Medicaid program exists to ensure that medically necessary services and equipment are made available to those who would not otherwise have the resources to purchase them. It is also fundamental that Medicaid is payor of last resort and always covers the least costly alternative that meets the beneficiary's medical need.

The Medicaid Provider Manual (MPM) provides, in pertinent part, as follows:

[] MEDICAL NECESSITY

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.
- 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.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

MPM, Medical Supplier, §1.5, July 1, 2013, pages 4, 5.

2.48 WHEELCHAIRS ...

[2.48.B. STANDARDS OF COVERAGE]

Re-numbered 7/1/13

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.

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 manual pediatric wheelchairs:

- Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without an assistive medical device or has a willing and able caregiver to push the chair **and** the wheelchair is required in a community residential setting.
- Is required for long-term use (greater than 10 months).
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.
- Is designed to be transportable.
- Is the most economic alternative available to meet the beneficiary's mobility needs.

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.

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MPM *Supra* pp. 88-89

In the present case, the Appellant's representative explained that the elbow stops were necessary to prevent the Appellant from throwing or relaxing his arms behind his chair – causing injury - because he lacked the capacity to extricate his arms from the pinch point without sustaining injury.

The Department's witness, ██████████, testified that on review of the amended PA that she denied the request for accessory elbow stops for lack of demonstrating medical necessity because she determined that the provision of the [approved] lap tray was adequate protection for the Appellant and the most cost effective solution under Medicaid policy. She added that neither the Appellant's range of motion nor muscle strength were documented on submission of PA.

On review, the Appellant failed to preponderate his burden of proof to establish that the Department improperly denied his request for elbow stop accessories. The Department correctly observed in its evidence and at hearing that the requested items were not covered under policy.

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 wheelchair accessories.

IT IS THEREFORE ORDERED that:

The Department decision is AFFIRMED.

ls/

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Docket No. 2013-50521 PA
Decision & Order

cc:

Date Signed: 8/16/2013

Date Mailed: 8/16/2013

***** 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.