

**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:

██████████

Appellant

\_\_\_\_\_ /

Docket No. 2013-62338 PA  
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 Appellant's request for hearing.

After due notice, a hearing was held on ██████████. ██████████, Appellant's Occupational Therapist at the nursing facility where he resides, appeared and testified on Appellant's behalf. Appellant also appeared but did not testify. ██████████, Appeals Review Officer, represented the Department. ██████████, Medicaid Utilization Analyst, appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny the Appellant's prior authorization request for a Q6 Edge Power Wheelchair and 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. Appellant is a ██████ year old Medicaid beneficiary, born ██████████, who has been diagnosed with CVA and hemiplegia. Appellant currently resides in a nursing facility. (Exhibit A, p 8)
2. On ██████████, the Department's consulting physician reviewed a prior authorization (PA) request from Appellant for a power wheelchair with accessories and determined that more information was needed because the PA request did not include medical necessity information and information regarding economical alternatives. (Exhibit A, p 5)
3. On ██████████, the Department requested additional information from Appellant. The request for additional information indicated that the resubmission would be considered a new PA request. (Exhibit A, pp 6-7)

4. In response to the request for additional information, on ██████████, the Department received a new PA request for a Q6 Edge Power Wheelchair and accessories for Appellant. (Exhibit A, pp 8)
5. On ██████████, the Department issued a Notification of Denial to Appellant and the medical supplier stating that the PA request was denied because the ██████████ PA request still did not contain sufficient medical necessity information and information regarding economic alternatives. (Exhibit A, pp 3-4)
6. On ██████████, the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (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.

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.

\* \* \*

### **Durable Medical Equipment (DME)**

DME are those items that are Food and Drug Administration (FDA) approved, can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when:

- It is medically and functionally necessary to meet the needs of the beneficiary.
- It may prevent frequent hospitalization or institutionalization.
- It is life sustaining.

\* \* \*

### **1.3 PLACE OF SERVICE**

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**

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.

\* \* \* \*

### **1.10 NONCOVERED ITEMS [CHANGE MADE 4/1/13]**

Items that are not covered by Medicaid include, but are not limited to:

\* \* \* \*

- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing.

\* \* \* \*

### **2.48 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS**

\* \* \* \*

#### **2.48.B. STANDARDS OF COVERAGE [RE-NUMBERED 7/1/13]**

\* \* \* \*

#### **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.

**2.48.C. PRIOR AUTHORIZATION FOR PURCHASE,  
RENTALS, REPAIRS, AND/OR REPLACEMENT OF**

**MOBILITY DEVICES [RE-NUMBERED 7/1/13; CHANGE  
MADE 10/1/13]**

\* \* \* \*

**Prior Authorization Process for Beneficiaries in the  
Institutional Residential Setting**

Prior authorization is required for Medicaid coverage and separate reimbursement for medically necessary power-operated vehicles and power or manual wheelchairs with custom-fabricated seating systems. The request for a resident assessment must be initiated by the treating physician with the stated medical reason for the referral.

Facility clinicians who are responsible for the overall nursing plan of care and treatment of the resident will prepare and submit prior authorization requests and medical documentation directly to the MDCH Program Review Division.

Refer to the Nursing Facility Coverages chapter for additional information regarding prior authorization of wheelchairs and custom-fabricated seating systems for beneficiaries in an institutional residential setting.

(Refer to the Prior Authorization Form subsection and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection of this chapter for additional information.)

MDCH Medicaid Provider Manual  
Medical Supplier Section  
July 1, 2013, pp 1, 3-5, 17-18, 88, 91  
Emphasis added.

## **10.8 DURABLE MEDICAL EQUIPMENT**

### **10.8.A. STANDARD EQUIPMENT**

\* \* \* \*

In addition, nursing services include positioning and body alignment and preventive skin care. The nursing facility is responsible for proper pressure relief and positioning. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

\* \* \* \*

#### **10.8.B.1. MEDICAL NECESSITY**

A physician's order by itself is not sufficient documentation of medical necessity, even when it is signed by the treating physician. Clinical documentation from the medical record must support the medical necessity for the request and substantiate the physician's order. In addition, Medicaid coverage is not based solely on a physician's order; the request must also meet the standards of coverage published by MDCH. (Refer to the Medical Necessity subsection of the Medical Supplier chapter for a complete description of medical necessity requirements.)

The nursing facility's responsibility for each resident's health care needs and other services, including patient care, transfers, safety, skin care, equipment, medical supplies, etc., are described in federal regulations and state licensure requirements. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Refer to the Medical Supplier chapter for additional information regarding Medicaid definitions and standards of coverage for mobility and custom-fabricated seating systems.

#### **10.8.B.2. NONCOVERED**

Power wheelchairs and custom-fabricated seating systems, including add-on components, are not covered outside the facility per diem rate when:

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- There is an appropriate economic alternative.
- The devices are not related to, or an integral part of, the nursing facility daily plan of care.
- The accessory or add-on component is deemed to be standard under the definition of a standard manual wheelchair.
- The wheelchair is used as a restraint or for the purpose of treating aberrant behaviors.
- The need for the wheelchair is a substitute for appropriate clinical nursing services, as defined in federal regulations.
- The wheelchair is inappropriate for the beneficiary's cognitive level or behavioral level.
- The beneficiary is unable to safely operate the wheelchair.
- A standard wheelchair meets functional need or outcome as defined in the plan of care.
- The device is ordered for nonstandard use (e.g., therapeutic modality or exercise).
- The device is ordered to increase sitting tolerance that exceeds acceptable medical guidelines for skin care and pressure.

MDCH Medicaid Provider Manual  
Nursing Facility Coverages  
July 1, 2013, pp 36-38  
Emphasis added

In the present case, the Department determined that the PA request should be denied because it did not include medical necessity information and information regarding economical alternatives, as required.

In his request for hearing, Appellant indicated that he would like a power wheelchair to be able to get to the meal room and to the bathroom for showering, grooming, toileting, etc. on his own. Appellant indicated that he is no longer able to ambulate and does not have the strength to propel a regular wheelchair. Appellant indicated that he would like the tilt mechanism to help him weight shift and to help with bed sores. (Exhibit 1)

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The Medicaid Utilization Analyst testified that the PA request received on [REDACTED] was for a Group 3 power wheelchair, meaning that the wheelchair was designed to support several power functions, such as a tilt and lift feature and a power articulating foot platform. The Medicaid Utilization Analyst indicated that in its request for additional information, the Department requested that Appellant rule out a Group 2 power wheelchair as a more economical alternative, include a copy of Appellant's current Manual Data Set (MDS), include a copy of Appellant's Plan of Care (POC), and provide medical necessity information for both the tilt and recline function and the power articulating foot platform. The Medicaid Utilization Analyst testified that the information received with the [REDACTED] PA request did not include the requested information. The Medicaid Utilization Analyst testified that no MDS was received. The Medicaid Utilization Analyst explained that an MDS is a packet of federally mandated information which would have covered all facets of Appellant's life in the nursing facility over a period of time. The Medicaid Utilization Analyst also indicated that the POC that was submitted with the request did not indicate the need for a power wheelchair and that the information submitted with the PA request did not rule out a Group 2 wheelchair as an economic alternative. Finally, the Medicaid Utilization Analyst testified that the information submitted did not contain medical necessity information for both the tilt and recline function and the power articulating foot platform.

The Medicaid Utilization Analyst explained that she had to base her decision on the information that she had at the time and, based on that information, the Department's denial was proper.

Appellant's Occupational Therapist (OT) testified that she worked closely with the medical provider on this request and felt that all of the requested information was provided. Appellant's OT indicated that she believed she addressed the medical necessity of the power wheelchair and accessories by including information regarding the pressure sores that Appellant has. Appellant's OT explained that because Appellant has weakness on his right side due to a stroke, he places all of his weight on his left side, which leads to pressure sores. Appellant's OT indicated that to relieve the pressure sores, the facility provides a pressure relieving cushion for Appellant to use in his wheelchair and recommends that Appellant lay in bed often to relieve pressure. Appellant's OT testified that until recently Appellant had been in his wheelchair approximately 12 hours per day, but because of his pressure sore he now has to spend a great deal of time in bed. Appellant's OT testified that she could not say why Appellant's MDS was not included with the PA request.

Based on the documentation submitted, Appellant did not meet the Medicaid standards of coverage and documentation requirements to establish medical necessity for the requested wheel chair and accessories. Appellant did not submit an MDS as requested, the information submitted did not rule out a Group 2 wheelchair as an economic alternative, and the information did not include medical necessity information for the tilt and recline or the power articulating foot platform. In fact, the POC submitted

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did not even indicate the need for a power wheelchair. Accordingly, the Department's denial must be upheld.

**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 Q6 Edge Power Wheelchair and accessories based on the submitted documentation.

**IT IS THEREFORE ORDERED** that:

The Department's decision is **AFFIRMED**.



Robert J. Meade  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

[REDACTED]  
cc: [REDACTED]

Date Signed: 10/8/2013

Date Mailed: 10/8/2013

**\*\*\* 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.