

**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. 2014-35456 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.*, following Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████, Appellant's mother and guardian, appeared and testified on Appellant's behalf. ██████████, Inquiry Dispute Appeals Resolution Coordinator, represented ██████████ of Michigan, the Medicaid Health Plan ("MHP"). Dr. ██████████, Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for a heavy duty manual wheelchair?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a ██████-year-old Medicaid beneficiary, born ██████████. (Exhibit A, p 8; Testimony)
2. On or about ██████████, the MHP received a Prior Authorization Request from ██████████ on behalf of Appellant for a heavy duty manual wheelchair. The diagnosis listed in the prior authorization request supporting the request for a heavy duty manual wheelchair was 343.9 infantile cerebral palsy. (Exhibit A, pp 8-14; Testimony)
3. On ██████████, the MHP advised Appellant and the supplier that the request for a heavy duty manual wheelchair was denied because the information supplied did not meet the standard of coverage found in Section 2.48.B of the Medical Supplier Chapter of the Medicaid Provider Manual

(MPM). (Exhibit A, pp 15-17; Testimony)

4. Appellant's Request for Hearing was received by the Michigan Administrative Hearing System (MAHS) on ██████████. (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.

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 MHPs.

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/EPSTD 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:

- (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

- (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- (e) 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 Medicaid Provider Manual, Medical Supplier Chapter, §2.48.B Standards of Coverage, April 1, 2014, p 84 states:

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 be able to use the wheelchair in the home environment (e.g., wheelchair must be able to fit through doorways and cross thresholds)
- Must identify other economic alternatives considered.
- 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. (Include patient's weight in the beneficiary's file.)

An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. (Include patient's weight in the beneficiary's file.)

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.

The MHP's medical director testified that the requested heavy duty manual wheelchair was not a covered item under *the Medicaid Provider Manual, Medical Supplier, §2.48.B Standards of Coverage*. The MHP's medical director stated that the information submitted did not show that Appellant was unable to ambulate less than 150 feet within one minute with or without an assistive medical device. The MHP's medical director also pointed out that the documentation submitted indicated that Appellant weighs only 231 pounds and a heavy duty wheelchair is only covered for persons who weigh more than 250 pounds. The MHP's medical director requested that the denial be upheld based on the submitted information.

Appellant's mother testified that Appellant is non-ambulatory and has had cerebral palsy since birth. Appellant's mother also indicated that Appellant weighs much more than 250 pounds, but that she has been unable to find a method to properly weigh him.

The MHP's medical director suggested that Appellant's mother go back to ██████████ ██████████ and ask them to resubmit the prior authorization request, to his attention, with the required information.

Appellant has failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the requested heavy duty manual wheelchair. As indicated above, heavy duty manual wheelchairs are covered only if a person is unable to ambulate less than 150 feet within one minute with or without an assistive medical device and the person weighs more than 250 pounds. While those criteria may be present here, the provider did not submit this information to the MHP. Given that the MHP can only base its decision on the information submitted, the denial was proper.

Appellant's mother indicated that she understood that she would need to have the provider resubmit the prior authorization to include the proper documentation.

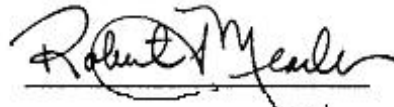
[REDACTED]
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DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for a heavy duty manual wheelchair was proper.

IT IS THEREFORE ORDERED that:

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



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

RJM/[REDACTED]

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

cc: [REDACTED]

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.