

**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. 2014-35707 QHP

██████████
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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. The Appellant appeared on her own behalf. ██████████, Paralegal appeared and testified on behalf of the Department's MHP ██████████. ██████████ Medical Director appeared as a witness for the MPH.

ISSUE

Did the MHP properly deny the Appellant's request for a power 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 (DOB ██████████) Medicaid beneficiary. (Testimony)
2. On ██████████, the MHP received a Prior Authorization Request from ██████████ on behalf of the Appellant for a power wheelchair. (Exhibit A pp. 14-32 and testimony).
3. On ██████████, denial letters were sent to the Appellant's doctor and ██████████. The reason for the denial was the information submitted along with the request did not show the Appellant had gone to therapy to help herself; it did not show the Appellant could use the wheelchair in all areas of her home, her bathroom door was too small to get through; it showed the Appellant could use a walker if she

stopped and rested; and, ██████████ rules were not met based on the information submitted with the PA request. (Exhibit A pp. 3-4 and testimony).

4. On ██████████, the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 35).

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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, 1/23/2013, pp. 22-23].

* * *

AA. Utilization Management

(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. 55].

The Medicaid Provider Manual, Medical Supplier Chapter, April 1, 2014, provides the following concerning Medicaid coverage of durable medical equipment including power wheel chairs. This chapter states in part:

SECTION 1 – PROGRAM OVERVIEW

* * *

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. [p. 1].

* * *

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. [p. 3].

* * *

1.8 DURABLE MEDICAL EQUIPMENT

1.8.A. STANDARD EQUIPMENT AND CUSTOM-FABRICATED SEATING

Standard equipment and custom-fabricated seating must be medically necessary and meet the medical and/or functional needs of the beneficiary. [p. 13].

* * *

SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

* * *

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

* * *

2.48.B. STANDARDS OF COVERAGE

* * *

Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings

May be covered if the beneficiary meets **all** of the following:

- Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals.
- Requires use of a wheelchair for at least four hours throughout the day.
- Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate.
- Has a cognitive, functional level that permits safe operation of a power mobility
- device with or without training.

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- Has visual acuity that permits safe operation of a power mobility device.
- For a three-wheeled power mobility device, has sufficient trunk control and balance. [pp. 20, 83, 85].

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP was unable to approve this prior authorization request because the information submitted along with the request did not show the Appellant had gone to therapy to help herself; it did not show the Appellant could use the wheelchair in all areas of her home, her bathroom door was too small to get through; it showed the Appellant could use a walker if she stopped and rested; and, ██████████ rules were not met based on the information submitted with the PA request.

Respondent's witnesses ██████████ and ██████████ along with the documents they submitted for the hearing establish that on ██████████, the MHP received a Prior Authorization Request from ██████████, on behalf of the Appellant for a power wheelchair. (See Exhibit A, pp. 14-32). On ██████████, denial letters were sent to the Appellant's doctor and ██████████. The reason for the denial was that the information submitted along with the request did not show the Appellant had gone to therapy to help herself; it did not show the Appellant could use the wheelchair in all areas of her home, her bathroom door was too small to get through; it showed the Appellant could use a walker if she stopped and rested; and, ██████████ rules were not met based on the information submitted with the PA request. (Exhibit A, pp. 3-4).

Respondent's witnesses stated that after they received the Appellant's request for hearing, which was not sent to them until ██████████ reviewed the materials submitted with the PA request, along with the information set forth in the Appellant's hearing request on ██████████ stated he was prepared to approve the request for a power wheelchair at that point, because new information contained in the Appellant's hearing request established that the Appellant's apartment was fully wheelchair accessible, contrary to what was indicated in the materials received back in ██████████ (Exhibit A, p. 2 and testimony). Unfortunately, ██████████ learned that the Appellant termed with ██████████ on ██████████ before he could approve the wheelchair. (Exhibit A, p. 33 and testimony).

The Appellant testified that she is now with ██████████ another MHP and that a new PA request for a power wheelchair has already been submitted to ██████████. In response, the Respondent's representatives agreed to contact ██████████ to insure that only one power wheelchair was ultimately approved for the Appellant.

[REDACTED]
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The Appellant failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied her request for a power wheelchair based upon the information submitted along with the PA request. The information submitted along with the [REDACTED] PA request did not establish that the Appellant would be able to utilize the wheelchair in all areas of her home. This fact alone provided sufficient justification to deny the request. Had the MHP been given the proper information in [REDACTED] it could have approved the wheelchair at that time. Unfortunately, the corrected information did not get to [REDACTED] in time to reverse the MHP's earlier denial.

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 power wheelchair was proper based upon the information submitted along with the PA request.

IT IS THEREFORE ORDERED that:

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

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

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.