STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-003905 PA

[redacted], [redacted] [redacted]

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.*, and upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on his own behalf.

[redacted], Appeals Review Officer, represented the Department of Health and Human Services ("DHHS" or "Department"). [redacted], MA, Medicaid Utilization Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's prior authorization request for both power tilt and recline functions as part of a new wheelchair?

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 [redacted] year-old Medicaid beneficiary who has been diagnosed with spastic quadriplegia cerebral palsy. (Exhibit A, pp. 28, 32).

2. Appellant had been using a Quantum Q 6000Z power wheelchair with a power tilt and recline that was purchased for him in Indiana, before he moved to [redacted] (Exhibit A, p. 34 and testimony).

3. On or about [redacted], the Department received a prior authorization request from Appellant's medical provider Wright & Filippis for a Permobil C300 power wheelchair and accessories for the Appellant. (Exhibit A, p. 30).

4. In response to that prior authorization request, the Department sent the provider a Request for Additional Information on [redacted]. (Exhibit A, p. 30 and testimony).

5. On [redacted] Appellant's medical provider submitted additional information in response to the Department's Request for Additional Information. (Exhibit A, pp. 28-29).

6. On [redacted], Wright & Filippis submitted additional information in connection with the request for a Permobil C300 power wheelchair and accessories for Appellant. (Exhibit A, pp. 14-48).

7. On [redacted], the Department sent Appellant both a Notice of Denial and a Notice of Amended Authorization. (Exhibit A, pp. 6-9).

8. As provided in those notices, while the requested power wheelchair and some accessories were approved, the tilt and recline functions were denied. (Exhibit A, pp. 6-11).

9. Regarding the reason for the partial denial, the Notice of Denial stated in part:

> The policy this denial is based on is Sections 1, 1.3 Place of Service, 1.5 Medical Necessity, 1.10 Non covered items, 1.8 Durable Medical Equipment, and 2.48 Wheelchairs, Pediatric Mobility, and Positioning Medical Devices, and Seating Systems of the Medical Supplier chapter of the Medicaid Provider Manual, which indicates:
>
> Medical necessity for tilt and recline (E1007) is not substantiated. Provider may resubmit on a separate PA for either tilt or for a most cost effective alternative . . . (Exhibit A, p. 6).

10. On [redacted], the Michigan Administrative Hearing System received the request for hearing filed by Appellant. (Exhibit A, p. 4).

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.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM). As stated in the MPM, "Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics." [*MPM, Medical Supplier*, *Section 1 – Program Overview*, January 1, 2015, p. 1].

Moreover, with respect to the place of service, the MPM states in part:

> **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. [*MPM, Medical Supplier, §1.3 Place of service,* January 1, 2015, p. 3].

Regarding medical necessity, the MPM also states in part:

> **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.

MDCH does not cover the service when Medicare determines that the service is not medically necessary.

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. [Emphasis added].

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1.5.A. PRESCRIPTION REQUIREMENTS

MDCH reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

***

1.5.C. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.5.D. CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

A CMN must contain all of the following:

- Beneficiary's name and address;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number (if initiated by the provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements Section of this chapter.

MDCH will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete

> the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.
>
> Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item. [*MPM, Medical Supplier,* January 1, 2015, pp. 4-7].

With respect to the durable medical equipment in dispute in this case, the MPM further states in part:

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

Power Tilt-in-Space or Recline Function in Both Community Residential and Institutional Residential Settings	**Power tilt-in-space <u>or</u> 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.

[*MPM, Medical Supplier,* January 1, 2015, pp. 88, 89, emphasis added].

Here, pursuant to the above policies, the Department denied the prior authorization request for a tilt and power recline function as part of a new wheelchair. As stated in the notice of denial and testified to by the Department's witness, the Department made that decision because the submitted documentation did not demonstrate that there was medical necessity for both tilt and recline functions. The Department's witness particularly noted that the tilt and recline functions would be serving the same purpose for relieving pressure and also that the Appellant is regularly provided with assistance, which could include repositioning and elevating, while in the home.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in making its decision. Moreover, the undersigned Administrative Law Judge's jurisdiction is limited to reviewing the Department's decision in light of the information it had at the time it made that decision.

Appellant testified that his prior wheelchair has both the power tilt and recline functions. He said it was purchased for him in [redacted] before he moved to [redacted]. He suggested that [redacted] should approve what [redacted] approved. Appellant said he wants the power tilt and recline to relieve pressure to avoid pressure sores. He said he is without assistance in the home on [redacted] and [redacted] from [redacted] pm to [redacted] pm. Appellant said he wants to be as independent as possible, and wants the power tilt and recline functions primarily to assist him while he is alone on [redacted] and [redacted].

The above quoted policy only provides for authorizing either the tilt or the recline function and the documentation submitted along with the prior authorization request does not establish medical necessity for both. Both functions are addressing pressure relief, and there is no identified need for both the tilt and recline functions as they would be addressing the same need for pressure relief.

The Appellant is free to submit a new prior authorization request for either a tilt or recline function, the most cost effective alternative for his new power wheelchair. With respect to the decision at issue in this case, however, the Department's denial must be affirmed given the information available at the time of the denial.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Appellant's prior authorization request for both tilt and power recline functions as part of his new wheelchair.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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 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.