STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-009910 PA

[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 telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted], Appellant's sister; [redacted] an occupational therapist at [redacted], another occupational therapist at [redacted], a physical therapist and director of rehabilitation at Heartland; Amy Simpson, a social worker at [redacted]; and [redacted], the administrator at [redacted]; also testified as witnesses for Appellant. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (DHHS or Department). [redacted], Medicaid Utilization Analyst, testified as a witness for the Department.

ISSUE

Did the Department properly deny Appellant's prior authorization request for a 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 [redacted] year-old Medicaid beneficiary who has been diagnosed with multiple sclerosis and who lives in a skilled nursing facility. (Exhibit A, page 10).

2. In [redacted] the Department received a prior authorization request for a power wheelchair and accessories for Appellant, along with supporting documentation. (Testimony of [redacted]i).

3. In response, the Department sent the request back and asked for additional information regarding Appellant's needs. (Testimony of [redacted]

4. On [redacted], the Department received a new prior authorization request for a power wheelchair and accessories for Appellant, along with supporting documentation. (Exhibit A, pages 10-98).

5. One of the forms submitted along with the prior authorization request indicated that three types of customized wheelchair documentation were required to accompany the form. (Exhibit A, page 25).

6. However, the box for one of the types of documentation, the box for the "Current Plan of Care that relates to the equipment entered", was unchecked in this case. (Exhibit A, page 25).

7. The documentation submitted along with the prior authorization request did contain several plans of care. (Exhibit A, pages 84-89).

8. However, only one of those plans of care addressed Appellant's wheelchair and it only stated:

> Staff assist with transportation via wheelchair as needed. Powered wheelchair would increase independence and mobility, and allow resident to step down to less restrictive living environment.

Exhibit A, page 85

9. On [redacted], the Department sent Appellant written notice that the prior authorization request for a power wheelchair and accessories was denied. (Exhibit A, pages 99-100).

10. Regarding the reason for the denial, the notice stated in part:

> The submitted nursing Plan of Care does not reflect the requested equipment. Provider may resubmit with a nursing Plan of Care.

Exhibit A, page 100

11. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter regarding the denial of the prior authorization request. (Exhibit A, pages 4-9).

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 statutes, 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). Regarding the specific request in this case, *i.e.* a request for a power wheelchair and accessories for a Medicaid beneficiary who loves in a skilled nursing facility, the applicable version of 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.
>
> For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. Wheelchair requests for the primary purpose of meeting resident nursing care needs that are the responsibility of the nursing facility are not covered. Wheelchairs for social or recreational purposes are the responsibility of the nursing facility. The Nursing Facility Chapter further describes coverage policy in the nursing facility.
>
> *MPM, January 1, 2015 version*
> *Medical Supplier Chapter, page 3*

> **SECTION 3 – QUALITY**
>
> The Michigan Department of Community Health (MDCH) is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that

promote and support person-centered planning and quality service delivery.

3.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and his support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.

MPM, January 1, 2015 version
Nursing Facility Coverages Chapter, page 3

7.5 PLAN OF CARE

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or his/her representative;
- The attending physician;

- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care;
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.

7.6 EVALUATION/RE-ASSESSMENT/PLAN REVISION

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or his representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.

MPM, January 1, 2015 version
Nursing Facility Coverages Chapter, pages 20-21

10.8 DURABLE MEDICAL EQUIPMENT

10.8.A. STANDARD EQUIPMENT

Standard durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

* * *

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, his family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

Medicaid policy has historically established that standard wheelchairs and other specified durable medical equipment are included in the Medicaid facility per diem rate in accordance with federal standards and state licensure requirements. The following describes what is meant by standard wheelchairs relative to current types of wheelchair products that are routinely prescribed and commonly available in the marketplace, and routinely prescribed and required for patient use in the long-term care environment.

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.

Standard manual wheelchairs are included in the facility's Medicaid per diem rate. A standard manual wheelchair is any wheelchair that is routinely prescribed and required for patient use in the long-term care environment. Standard manual wheelchairs that must be available to meet health and care standards include wheelchairs and accessories that are manufactured stock items, including heavy-duty, light- or ultra-light –weight and/or -strength; hemi chairs; wheelchairs with adjustable or reclining backs; manual tilt-in-space; removable/adjustable arms; variable seat height, width or depth; anti-thrust seats; laterals, abductors, and adductors; or other non-custom positioning options. In addition, pressure-relief positioning cushions, positioning pillows, trochanter rolls, etc. required for proper beneficiary use of the wheelchair or the provision of nursing services are the responsibility of the facility.

10.8.B. CUSTOM-FABRICATED SEATING AND/OR POWER WHEELCHAIRS

Custom-fabricated seating and/or power wheelchairs for nursing facility residents may be covered when the established standards of coverage are met and the severity and intensity of the disease process requires custom-fabricated seating or a power-operated wheelchair as medically necessary and is an integral part of the facility's daily nursing plan of care.

Repairs to custom-fabricated equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.

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:

- 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.

10.8.C. PRIOR AUTHORIZATION

Prior authorization is required for Medicaid coverage of medically-necessary power wheelchairs, custom-fabricated seating, and manual wheelchairs with custom-fabricated seating systems outside of the facility per diem rate. The treating physician must initiate the referral for custom-fabricated seating or a power-operated vehicle (POV) based on an identified medical need in the plan of care. Facility clinicians who are responsible for the overall nursing plan of care for, and treatment of, the resident prepare and submit prior authorization requests, medical documentation, and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) within 90 days of the date the evaluation was completed. (Refer to the Prior Authorization subsection of the Medical Supplier chapter for additional information, and to the Forms Appendix for a copy of the form and form completion instructions.)

MPM, January 1, 2015 version
Nursing Facility Coverages Chapter, pages 37-40

Here, the Department sent Appellant written notice that the prior authorization request for a power wheelchair and accessories was denied on the basis that the submitted nursing plan of care did not reflect a need for the requested equipment. The Department's denial also noted that the provider could resubmit the request with a new nursing plan of care.

As provided in the above policies and testified to by the Department's witness, while Medicaid covers durable medical equipment (DME), such as wheelchairs, in a skilled nursing facility, most DME, including standard wheelchairs, are included in the facility's per diem rate and are therefore not separately approved or paid for by Medicaid. Moreover, while custom power wheelchairs for nursing facility residents may be covered and separately approved, the custom power wheelchairs must be both medically necessary and an integral part of the facility's daily nursing plan of care. The Department's witness further testified that the nursing plan of care in this case was very broad regarding Appellant's need for a wheelchair and it failed to reflect that the custom power wheelchair would be an integral part of her plan of care.

In response, Appellant's witnesses consistently testified regarding why the power wheelchair and accessories were needed in this case. The occupational and physical therapists also testified that Appellant's plan of care does not specifically provide that a custom power wheelchair is an integral part of her plan of care because Appellant does not have the custom power wheelchair yet and the plan of care only reflects the current services provided. Appellant's witnesses further testified that Appellant's condition is only going to get worse in the future and that she needs the power wheelchair and accessories.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in denying the prior authorization request in this case. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information that was available at the time the decision was made.

Given the record in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that the Department's decision must therefore be affirmed. To be approved, the requested custom power wheelchair must be an integral part of the facility's daily nursing plan of care for Appellant. However, the plan of care submitted in this case merely provided that the facility's staff assist Appellant with transportation via wheelchair as needed and that a powered wheelchair would increase independence, increase mobility, and allow Appellant to step down to a less restrictive living environment. Such broad statements fail to demonstrate that the custom power wheelchair is essential to Appellant's plan of care or specifically discuss how the current plan of care relates to the DMR requested. Moreover, while the therapists testified that the current plan of care does not reflect that a custom power wheelchair is an integral part of her plan of care because Appellant does not have the custom power wheelchair yet and the plan of care only reflects the current services provided, the MPM clearly requires that the plan of care identify and address all aspects

of a resident's health and well-being, not just those services provided by the facility or covered by insurance.

As indicated by the notice of denial, Appellant and her provider are free to resubmit the prior authorization request along with an updated plan of care. Moreover, if that request is denied, she can then file another request for an administrative hearing. However, regardless of any future requests, the Department's decision in this case must be affirmed given the documentation submitted and the available information.

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 a power wheelchair and accessories.

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

Steven Kibit
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.