



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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[REDACTED] MI [REDACTED]

Date Mailed: October 8, 2024
MOAHR Docket No.: 24-008927
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on October 1, 2024. [REDACTED] Petitioner, appeared on his own behalf. Leigha Klaver, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Christine Wixtrom, an Analyst in the Program Review Division, testified as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny Petitioner's prior authorization request for a wheelchair and accessory?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. On June 6, 2024, the Department received a prior authorization request for a wheelchair and accessories submitted on Petitioner's behalf. (Exhibit A; Testimony).

2. On July 8, 2024, the Department sent Petitioner a request for additional information. The document requested the following:
 - Resubmit with section 7 of the MSA-1656 completed.
 - The submitted MSA-1656 documents the goal of the requested power wheelchair is for assisted mobility. Please explain. Per section 2.47 of the Medical Supplier chapter, the coverage of a power wheelchair requires the beneficiary demonstrates safety and independence with the operation of the device at the time of the evaluation. The approval of the power wheelchair is contingent on the beneficiary's documented ability.
 - Resubmit with therapist attestation that an in-person trial with the requested power wheelchair has occurred and that the beneficiary is independent and safe in the operation of the requested power wheelchair.
 - Resubmit with the distance the beneficiary is able to independently operate the requested power wheelchair.
 - Resubmit with the current and requested wheelchair seat width and depth.
 - Explain the medical need for a power wheelchair for a beneficiary with a lower extremity prosthesis.
 - Resubmit with the documentation of medical need for all requested procedure codes. Only those items justified by the medical need will be considered.
3. On or around July 22, 2024, the Petitioner resubmitted documentation with notations. (Exhibit A.)
4. On July 29, 2024, the Department sent Petitioner written notice that the request for a wheelchair and accessories had been denied. (Exhibit A; Testimony).
5. With respect to the reason for the denial, the notice stated:

The policy this denial is based on is Section 1.6, 1.8, and 2.47 of the Medical Supplier and Nursing Facility Coverages chapters of the Medicaid Provider Manual. Specifically:

- The required documentation was not received. Please refer to prior authorization 1001057450 for the required documentation.
- Therapist attestation that an in-person

trial with the requested power wheelchair has occurred and that the beneficiary is independent and safe in the operation of the requested power wheelchair was not received. Per section 2.47 of the Medical Supplier chapter, the coverage of a power wheelchair requires the beneficiary demonstrates safety and independence with the operation of the device at the time of the evaluation. The approval of the power wheelchair is contingent on the beneficiary's documented ability.

- The distance the beneficiary is able to independently operate the requested power wheelchair was not documented.
- The documentation did not substantiate the medical need for E0973.
- The provider is welcome to resubmit for the requested power wheelchair once the required documentation is available for review.
- Please refer to the Medical Supplier Chapter, Sections: 1.6, 1.8, and 2.47.¹

6. On August 13, 2024, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter. (Exhibit A).

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) and, in part, the applicable version of the MPM states:

¹ Exhibit A, p 11.

1.6 MEDICAL NECESSITY

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need 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, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS NP or PA. 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 MDHHS standards of coverage.²

1.8 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-fabricated DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

* * *

² Medicaid Provider Manual, Medical Supplier, July 1, 2024, p 9.

1.8.B. EVALUATION AND MEDICAL JUSTIFICATION FOR COMPLEX SEATING SYSTEMS AND MOBILITY DEVICES FORM

The Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) provides a standard assessment tool for a licensed medical professional to use when performing assessments for wheelchairs, seating systems, and pediatric standing systems. The form is required for all ages and covered settings. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)

The MSA-1656 serves as a baseline evaluation for the beneficiary and is a clinical assessment that also includes an assessment of current technology options available to meet the beneficiary's medical and functional goals. The evaluation process assists the evaluator in determining the most appropriate level of equipment that will aid the beneficiary in completing mobility related activities of daily living (MRADL). Once problems and goals are determined, the process includes a patient simulation trial using comparable loaner or demonstration technology. The patient simulation is performed jointly by the clinician and a qualified assistive technology practitioner

The initial MSA-1656 is retained on file by MDHHS. A new MSA-1656 is not required for additions or revisions to a seating system or mobility item unless there is a change in the beneficiary's functional status.

- Addendum A: Mobility/Seating – This form must be completed and submitted with MSA-1656 and MSA-1653-D when requesting complex seating, a manual wheelchair with accessory add-ons, power wheelchairs, scooters, and power accessories. The evaluator must complete only the sections that apply to the requested equipment and accessories.
- Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs – This form must be completed and submitted with MSA-1656 and

MSA-1653-D when requesting these items. The evaluator must complete only the sections that apply to the requested equipment and accessories.

Form completion instructions describe the responsibilities of the treating physician, the physical and occupational therapist, the medical supplier, and the nursing facility staff (when appropriate).

The MSA-1656 must be submitted within 90 days of the date the evaluation was completed. Completion/submission of the MSA-1656 without supporting documentation from the medical record is not acceptable. The use of medical supplier-created mobility forms or "canned" documentation statements are not acceptable and may not be used as a substitute for information from the medical record or for completion of required MDHHS forms.

The outpatient therapy provider or the nursing facility may bill for the mobility and seating assessment performed by the licensed medical professional using HCPCS code 97542.³

Here, as discussed above, Petitioner's request for a wheelchair and accessories was denied pursuant to the above policies. Specifically, the documentation provided lacked the necessary information to meet the medical necessity requirements.

Petitioner argued a need for the wheelchair and the use of an existing wheelchair borrowed from a friend until he gets approved for one. Petitioner, however, did not dispute the information that was missing in the prior authorization documentation.

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

Given the record and applicable policy in this case, Petitioner has failed to meet the burden of proof and the Department's decision must be affirmed.

³ Medicaid Provider Manual, Medical Supplier, July 1, 2024, pp 13-15.

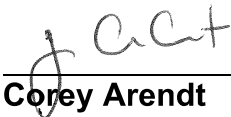
DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS, THEREFORE, ORDERED that:

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

CA/pe



Corey Arendt
Administrative Law Judge

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Via Electronic Mail:

Agency Representative

Leigha Klaver
MDHHS Appeals Section
P.O. Box 30807
Lansing, MI 48909
Klaverl@michigan.gov

DHHS Department Contact

Gretchen Backer
MDHHS
P.O. Box 30479
Lansing, MI 48909
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Mary Carrier
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Via First Class Mail:

Petitioner

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