[redacted]
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[redacted] **MI** [redacted]

Date Mailed: March 2, 2020
MOAHR Docket No.: 19-012461
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 et seq; 42 CFR 438.400 et seq; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on January 23, 2020. [redacted], Sister and Guardian, represented the Petitioner. [redacted], Occupational Therapist, Therapy Program Manager, [redacted]; and [redacted], Regional Director of Sales, Rehab Medical, appeared as witnesses for Petitioner. Emily Piggott, Appeals Review Officer, represented the Department of Health and Human Services (Department). Christine Wixtrom, Program Review Analyst, appeared as a witness for the Department.

During the hearing proceeding, the Department's Hearing Summary packet was admitted as Exhibit A, pp. 1-206.

ISSUE

Did the Department properly deny Petitioner's request for prior authorization for a custom manual 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. Petitioner is a [redacted]-year-old Medicaid beneficiary, date of birth [redacted] 1971. (Exhibit A, p. 5)

2. Petitioner resides at [redacted], a nursing facility. (Exhibit A, p. 9)

3. On or about October 28, 2019, the Department received a prior authorization request for a custom manual wheelchair for Petitioner. (Exhibit A, pp. 9-168)

4. On November 4, 2019, the Department issued a Notification of Denial to Petitioner stating the request for a new manual wheelchair was denied because:

    - This electronic request was submitted incorrectly and cannot be reviewed. It is the provider's responsibility to enter the brand names, descriptions, and part numbers in CHAMPS for each standard code and all items included under those codes to allow for accurate review and reimbursement. This information should be entered by the provider into the Remarks field available for each procedure code, simply sending a quote or invoice does not fulfil this requirement.
    - The required documentation for a wheelchair prior authorization request for long term care residents was not submitted. The current MDS was not included with this submission as required by policy for beneficiaries in long term care. Please resubmit with all the required documentation.
    - The medical need was not substantiated for custom seating for this beneficiary. Please note: When no custom seating is medically necessary, mobility devices are included in the per diem charge for long term care.
    - Please note: The provider address in CHAMPS is incorrect, and the provider on the MSA-1653-D that was uploaded does with this submission does not match the NPI number in CHAMPS.
    - Please refer to the Medical Supplier Chapter, Sections: 1.4, 1.6, 1.8. 1.11, and 2.47 and the Nursing Facility Coverages Chapter Sections: 10.8 and 10.21.

    (Exhibit A, pp. 7-8)

5. On December 2, 2019, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's Request for Hearing. (Hearing Request)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.

1.9 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services.

MDHHS Medicaid Provider Manual,
Practitioner Chapter, (October 1, 2019, p. 4)

1.4 PLACE OF SERVICE

Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in any non-institutional setting in which normal life activities take place except for skilled nursing facilities, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.

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. The following items are exempt from the per diem rate and must be billed by the medical supplier:

- Air-fluidized beds
- Bariatric beds
- Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.

- Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis)
- Orthotics and Prosthetics
- Parenteral nutrition, including all supplies, equipment, and solutions
- Powered air flotation bed (low air loss therapy)
- Selected surgical dressings
- Shoes and Additional Components

MDHHS Medicaid Provider Manual,
Medical Supplier Chapter, (October 1, 2019, p. 6)

1.6 MEDICAL NECESSITY [CHANGE MADE 10/1/19]

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 **(added per bulletin MSA 19-10)** 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.

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 MDHHS 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 safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.
- The function of the service/device:
  - meets accepted medical standards, practices and 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, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.
- The service/device meets the standards of coverage published by MDHHS.
- 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.

MDHHS 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.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

MDHHS Medicaid Provider Manual,
Medical Supplier Chapter, (October 1, 2019, pp. 7-8)

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.)

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screens.
- Medical need for an item beyond the MDHHS Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required as noted in the Medicaid Code and Rate Reference tool.

Prior authorization coverage determinations are based on the evaluation of the documentation received and all of the following:

- The beneficiary's benefit plan scope and coverages (e.g., Emergency Services Only);
- Food and Drug Administration (FDA) and manufacturer product intended usage(s);
- Healthcare Common Procedure Coding System (HCPCS) Level II code definitions as deemed by the American Medical Association; and
- The safety and effectiveness of the product for age-appropriate treatment as substantiated by current evidence-based national, state and peer-review medical guidelines.

MDHHS reserves the right to a final determination of whether the practitioner's submitted medical documentation sufficiently demonstrates the medical necessity for the services requested.

Beneficiaries may request a fair hearing in accordance with 42 CFR Part 431 Subpart E for any MDHHS coverage denials. (Refer to the General Information for Providers chapter for additional information.)

1.8.A. PRIOR AUTHORIZATION FORM

Requests for PA must be submitted on the Special Services Prior Approval- Request/Authorization form (MSA-1653-B) or, for mobility and custom seating items, submit the Complex Seating and Mobility Device Prior Approval-Request/Authorization form (MSA-1653-D). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must use the specific HCPCS code and the code description. A NOC code may not be used unless the use of a NOC code for the item has been approved by the PDAC. The brand, model, product or part number must be stated on MSA-1653-B or MSA-1653-D with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the Coverage Conditions and Requirements section of this chapter for additional information regarding standards of coverage and payment rule requirements.)

PA request forms and attached documentation may be mailed or faxed to the MDHHS Program Review Division. (Refer to Directory Appendix for contact information.)

Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

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.

MDHHS Medicaid Provider Manual,
Medical Supplier Chapter, (October 1, 2019, pp. 11-13)

1.9 DURABLE MEDICAL EQUIPMENT

1.9.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.

- Standard equipment and accessories are products ordered from manufacturer stock. Measuring and custom-fitting a medical device to a beneficiary or custom-assembling a medical device to fit a beneficiary's needs using manufactured stock pieces is not considered to be custom-fabricated.
- Custom-fabricated seating is made from clinically derived, rectified castings, tracings, and other images (such as x-rays) of the beneficiary's body part.

  It also includes computer-aided design/computer-aided manufacturing (CAD/CAM) technology used for the seating system. Computer-aided design/manufacturing must be performed by an experienced clinician along with a Certified Rehabilitation Technology Supplier (CRTS) or

> Assistive Technology Professional (ATP) who has completed the training course offered by the manufacturer. The outcome should be created jointly by the clinician and the CRTS/ATP. The cost for performing these activities is included in the Medicaid payment rate for the custom-fabricated seating system.
>
> MDHHS will only consider coverage of custom-fabricated seating when a standard item will not meet the medical or functional needs of the beneficiary. All custom-fabricated equipment requires prior authorization. Once the custom-fabricated equipment is purchased, it becomes the property of the beneficiary. To be covered as custom-fabricated, the item must meet the MDHHS definition of custom-fabricated. A manufacturer's use of the term custom-fabricated for an item that does not meet the MDHHS definition will not be reimbursed as custom-fabricated. MDHHS reserves the right to determine and apply HCPCS codes used for the purpose of reimbursement.
>
> *MDHHS Medicaid Provider Manual,*
> Medical Supplier Chapter, (October 1, 2019, p. 16)

The Medical Supplier Chapter also addresses noncovered items, which includes Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited Staffing. *MDHHS Medicaid Provider Manual, Medical Supplier Chapter, (October 1, 2019, pp. 22-23)*

> **2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS [RE-NUMBERED 10/1/19]**
>
> **2.47.A. DEFINITIONS [RE-NUMBERED 10/1/19]**
> **Wheelchair**
> A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc.
>
> ***
>
> **Institutional Residential Setting**
> An institutional residential setting refers to a nursing facility, State Veterans' Home, hospital long-term care unit, or county medical care facility.

***

Manual Wheelchair in Institutional Residential Setting
Coverage and reimbursement for all standard manual wheelchairs for an institutional residential setting is included in the per diem rate.

Manual Wheelchair with Custom- Fabricated Seating System in both Community Residential and Institutional Residential Settings

May be covered if **all** of the following are met, in addition to the Standards of Coverage listed under Manual Wheelchair in Community Residential Setting:

- Medical documentation provides a clinical assessment of the specific functional/clinical need for a custom-fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage.
- Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width.
- Is an integral part of the care regimen in the community residential setting or the daily nursing plan of care in an institutional residential setting.

***

Custom-Fabricated Seating Systems

May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. May be covered if all of the following are met:

- Two or more of the above clinical indications are documented in the medical record and in the mobility assessment, and the severity of the clinical indications cannot be accommodated by a standard seating system.
- Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width.

- Must document the reason for the selection when the system cannot be used in more than one mobility device.
- Is the most economical alternative available to meet the beneficiary's mobility needs.

MDHHS Medicaid Provider Manual,
Medical Supplier Chapter, (October 1, 2019, pp. 105-109)

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:

- Standard manual wheelchairs
- Wheelchairs for transport in or out of the facility

(rest of list omitted by ALJ)

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 MDHHS. (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.)

MDHHS Medicaid Provider Manual,
Nursing Facility, Coverages Chapter, (October 1, 2019, pp. 34-37)

The Nursing Facility Coverage Chapter also addresses the nursing care that is required to be provided in a nursing facility. *MDHHS Medicaid Provider Manual, Nursing Facility Coverage Chapter, (October 1, 2019, pp. 45-46)*

The Department's Program Review Analyst went over the information submitted for the prior authorization request and policy in detail explaining why this request was denied. Part of the denial was based on errors with the submission itself, such as: the mismatch with the provider name, address, and NPI number and not providing the required information in CHAMPS for each standard code (brand names, descriptions, part numbers, and all items included under each code). Additionally, the submitted information did not establish medical necessity for custom seating for Petitioner. Multiple sections of the required evaluation forms were discussed. For example, the documentation indicated flexibility or partial flexibility for Petitioner's trunk, hips, and pelvis. It was also noted that the current MDS was not provided, which is required. When no custom seating is medically necessary, mobility devices are included in the facility's Medicaid per diem rate. (Exhibit A; Program Review Analyst Testimony)

Petitioner's sister explained that Petitioner has come a really long way and overcome many obstacles. Last March, the respiratory therapist stated that Petitioner needs to start getting off the left lobe of her lung, which is closing. Petitioner needs to start getting

up out of bed. Recently, the gastric doctor has also stated that Petitioner has to get up out of bed due to acid damaging her esophagus. The facility tried Petitioner in a standard wheelchair, but Petitioner could not sit up in that chair. Petitioner needs this chair to go forward and her health is at risk. (Sister Testimony)

The Occupational Therapist did the evaluation with Petitioner. It was noted that the MDS was submitted to the medical supplier company, along with all the other information. A high back recline chair was tried with Petitioner, but Petitioner was posteriorly pelvic tilting and sliding right out of the chair. The Occupational Therapist explained why she feels this manual tilt in space wheelchair is necessary for Petitioner. (Occupational Therapist Testimony)

The Regional Director of Sales confirmed that Crow Creek Therapeutics was recently bought out by Rehab medical. This would have affected the name, address, and NPI mismatch. (Regional Director of Sales Testimony)

Overall, the denial of the October 28, 2019, prior authorization request was proper based on submitted documentation. There were technical issues with the electronic submission. Further, the documentation submitted did not establish medical necessity for custom seating for Petitioner. Accordingly, the Department's denial of this prior authorization request for a manual tilt in space wheelchair for Petitioner is upheld based on the documentation submitted with this request.

As discussed, another prior authorization request can be submitted with additional supporting documentation, for example clarifying why custom seating is medically necessary for Petitioner, and any needed corrections to the technical issues with the submission.

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 request for prior authorization for a custom manual wheelchair based on the information submitted with the October 28, 2019, prior authorization request.

IT IS, THEREFORE, ORDERED that:

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

CL/dh

Colleen Lack
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

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

DHHS -Dept Contact	Gretchen Backer 400 S. Pine, 6th Floor PO Box 30479 Lansing, MI 48909
DHHS Department Rep.	M. Carrier Appeals Section PO Box 30807 Lansing, MI 48933
Authorized Hearing Rep.	[redacted] [redacted] [redacted] MI [redacted]
Agency Representative	Emily Piggott 222 N Washington Square Suite 100 Lansing, MI 48909
Petitioner	[redacted] [redacted] [redacted] MI [redacted]