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Date Mailed: November 10, 2020
MOAHR Docket No.: 20-006008
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.,* upon the Petitioner's request for a hearing.

After due notice, a hearing was held on October 28, 2020. [redacted], Petitioner's mother, appeared on behalf of the Petitioner. Emily Piggott, Appeals Review Officer, represented the Department of Health and Human Services (Department). Adam Schlafman, Program Review Analyst, appeared 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 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. Petitioner is a Medicaid beneficiary, born [redacted] 2007, who has been diagnosed with cerebral palsy. (Exhibit A, pp 5, 8; Testimony.)

2. On or around June 19, 2020, Respondent received from Binson's, on behalf of Petitioner, a Prior Authorization (PA) request for a wheelchair and accessories. (Exhibit A, pp 7-23; Testimony.)

3. The PA request indicated Petitioner needed a headrest cover/canopy to accommodate Petitioner's sensitivity to excessive sun exposure and needed an

under-seat storage basket to carry disposable briefs, medications, and nutritional supplies. (Exhibit A, p 14; Testimony.)

4. On July 9, 2020, the Department sent Petitioner an Amended Authorization. The authorization indicated Petitioner's request for a folding pediatric adjustable wheelchair and cushioned headrest were approved, but that the request for a headrest cover and under seat storage basket were denied. (Exhibit A, pp 5-6; Testimony.) The notice stated the following:

    - The documentation does not support the medical necessity for the requested headrest cover canopy or under seat storage basket. Commercial products are available. Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.) are not covered.

    - Refer to the Medical Supplier chapter sections: 1.6, 1.11, and 2.47. (Exhibit A, p 5.)

5. On September 28, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (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 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, the applicable version of the MPM states in part:

> **SECTION 1 – PROGRAM OVERVIEW**
>
> This chapter applies to Medical Suppliers/Durable Medical Equipment and Orthotists/Prosthetists.
>
> The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.
>
> The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.

This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and Michigan Department of Health and Human Services (MDHHS) includes both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics.

Below are common terms used throughout this chapter:

* * *

Durable Medical Equipment (DME)

Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional* setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of illness, injury or disability. 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.

* * *

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, 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, 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.

* * *

1.6.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 medial 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).

* * *

1.8 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.

1.11 NONCOVERED ITEMS

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)

* * *

- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)[1]

The Department's Analyst testified the documentation provided with the PA request failed to establish the medical necessity for the items being denied. Specifically, the provided documentation failed to show how other commercial items were not practical and/or show the Petitioner as having a medical condition that creates the light sensitivity issue.

Petitioner's mother argued the items were needed and that they had been provided in the past. Petitioner's mother failed, however, to show where in the provided documentation that it established how other commercial products have either been tried and failed, or that they were not practical. Additionally, just because benefits may have been provided in the past, does not guarantee future allocation.

Petitioner 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 (ALJ) is limited to reviewing the Department's decision considering the information that was available at the time the decision was made.

Given the record and available information in this case, I find that Petitioner has failed to meet this burden of proof and that the Department's decision must therefore be affirmed.

[1] MPM, Medical Supplier Chapter, July 1, 2020, pp 1, 9-10, 12-14, 24, 26.

DECISION AND ORDER

I find, based on the above findings of fact and conclusions of law, finds that the Department properly denied Petitioner's prior authorization request for wheelchair accessories.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

CA/dh

Corey Arendt
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
Petitioner	[redacted] [redacted] [redacted] MI [redacted]
Authorized Hearing Rep.	[redacted] [redacted] [redacted] MI [redacted]
Agency Representative	Emily Piggott 222 N Washington Square Suite 100 Lansing, MI 48909