[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: November 22, 2021
MOAHR Docket No.: 21-004705
Agency No.:
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

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 November 10, 2021. [redacted], Petitioner's sister and legal guardian, appeared and testified on Petitioner's behalf. John Lambert, 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.

During the hearing, the Department offered one evidence packet/exhibit that was admitted into the record as Exhibit A, pages 1-74. Petitioner did not offer any exhibits.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for a 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 [redacted]-year-old Medicaid beneficiary who has been diagnosed with, among other conditions, multiple sclerosis; bilateral acquired absence of unspecific leg above knee; major depressive disorder, recurrent; muscle wasting and atrophy; adjustment disorder with depressed mood; neuromuscular dysfunction of bladder; and unspecified dementia. (Exhibit A, pages 11-12, 29).

2. She lives in a nursing facility, with nursing facility services covered by the Department and paid for at a per diem rate. (Exhibit A, pages 15, 30; Testimony of Analyst).

3. On September 8, 2021, the Department received a prior authorization request for a wheelchair and accessories submitted on Petitioner's behalf. (Exhibit A, pages 7, 11-41).

4. In part, that request identified the specific HCPCS codes for the specific requested items, with none of the codes being for custom items. (Exhibit A, page 11; Testimony of Analyst).

5. The request further provided that the items were being requested due to Petitioner's impaired neuromuscular system, spinal posture, and lower extremity amputations; with Petitioner unable to sit safely in a standard wheelchair or geri chair. (Exhibit A, page 12).

6. Supporting documentation submitted along with the request also stated that Petitioner is currently using a facility-owned geri chair, and that the goal of the new chair is for her to increase her time out of bed and participation in activities. (Exhibit A, pages 14, 16).

7. The section of the documentation requesting identification of the medical need for accessories was left blank. (Exhibit A, page 19).

8. The occupation therapist also checked the box for "planar/non-custom contour", while leaving blank the section stating: "If requesting custom seating, specify why planar/non-custom does not meet beneficiary's needs." (Exhibit A, page 19).

9. No letter of medical necessity was attached to the request, but a work order attached to the request did contain handwritten notes as to why each requested item was required. (Exhibit A, page 22).

10. On September 15, 2021, the Department sent Petitioner written notice that the request for a wheelchair and accessories had been denied. (Exhibit A, pages 9-10).

11. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Section 1.4, 1.6, 1.8, 1.11, 2.47, 10.8 and 10.21 of the Medical Supplier and Nursing Facility Coverages chapters of the Medicaid Provider Manual. Specifically:
>
> - The medical need for custom seating was not substantiated nor requested specific to this beneficiary. The severity of the clinical indications can be accommodated by a standard seating

system. When no custom seating is medically necessary, mobility devices and other non-custom positioning options are included in the per diem charge for long term care.

- Nursing care included in the per diem rate includes proper positioning in the wheelchair to prevent deformity.

- Please note: future requests must include the entire MDS and plan of care.

- Please note: future requests must include the medical need for manual recline in addition to the tilt in space.

- Please refer to the Medical Supplier Chapter, Sections: 1.4, 1.6, 1.8, 1.11, and Nursing Facility Coverages, Sections: 10.8 and 10.21

Exhibit A, page 10

12. On October 11, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding the Department's decision. (Exhibit A, pages 4-6).

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:

1.4 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.

MPM, July 1, 2021 version
Medical Supplier Chapter, pages 7-8
(italics added for emphasis)

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.

MPM, July 1, 2021 version
Medical Supplier Chapter, page 9
(italics added for emphasis)

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.)

* * *

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.

MPM, July 1, 2021 version
Medical Supplier Chapter, pages 13-15
(italics added for emphasis)

1.11 NONCOVERED ITEMS

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

* * *

- Custom seating for secondary and/or transport chairs

MPM, July 1, 2021 version
Medical Supplier Chapter, page 25

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:*

* * *

- *Wheelchairs for transport in or out of the facility*

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.)

MPM, July 1, 2021 version
Nursing Facility Coverages Chapter, pages 33-36
(italics added for emphasis)

10.21 NURSING CARE

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record

- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions

- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings

- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions

- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel

- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores

- Provision of bed baths

- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores

- Administration of intravenous solutions on a regular and continuing basis

- Administration of tube feedings

- Nasopharyngeal aspiration required for maintenance of a clear airway

- Care of a colostomy or iliostomy during early postoperative period, on an on-going basis, and conducting colostomy training

- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures

- Use of intermittent positive pressure breathing equipment and nebulizers

- Care of catheters

- Care of tracheostomies, gastrostomies, and other indwelling tubes

- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration

- Identifying the need for, and insuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services

- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator

- Training and assistance in transfer techniques (bed to

wheelchair, wheelchair to commode, etc.)

- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living

- Normal range-of-motion exercises as part of routine maintenance nursing care

- Pain assessment and management

MPM, July 1, 2021 version
Nursing Facility Coverages Chapter, pages 44-45

Here, as discussed above, Petitioner's request for a wheelchair and accessories was denied pursuant to the above policies and on the basis that Petitioner was only requesting standard items and, for residents of nursing facilities like Petitioner, standard items, including manual wheelchairs and accessories, are the responsibility of the nursing facility and paid for as part of the facility's per diem rate.

In appealing the denial, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred in denying her 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 her burden of proof and the Department's decision must be affirmed.

During the hearing, the Department's witness credibly and fully explained why the request was denied. In particular, she went through the documentation submitted and the applicable policy, detailing both how the request in this case for standard, non-custom items and how the applicable policy provides that such items are the responsibility of the nursing facility where Petitioner lives. Moreover, rather than disputing the Department's findings, Petitioner's representative instead argues that Petitioner needs a new wheelchair and that the request should not be denied on a technicality. However, even without the required letter of medical necessity in this case, the denial was not based on a lack of need and who is responsible for the requested standard wheelchair is a matter of policy, not a mere technicality.

Petitioner is free to request the standard, non-custom wheelchair through her nursing facility or, to the extent Petitioner's representative has updated or additional information to provide, then she and the provider can always submit a new prior authorization request with that information. With respect to the decision at issue in this case however,

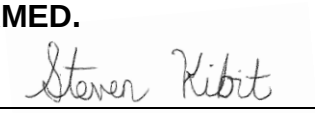
the Department's decision must be affirmed given the available information and applicable policies.

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.**



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Steven Kibit
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

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