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Date Mailed: January 12, 2024
MOAHR Docket No.: 23-007937
Agency No.: [redacted]
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 December 20, 2023. [redacted] Petitioner's brother, appeared and testified on Petitioner's behalf, with Petitioner and [redacted] another brother, also present. John Lambert, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Review Analysts Christine Wixtrom and Mellody London testified as witnesses for the Department.

During the hearing, Petitioner submitted medical documentation that was admitted into the record without objection as Exhibit #1, pages 1-4. The Department also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-74. No other proposed exhibits were submitted.

ISSUES

Did the Department properly deny Petitioner's prior authorization requests for (1) a light wheelchair and accessories and (2) a gel pressure mattress?

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, hemiplegia and hemiparesis following cerebral infarction. (Exhibit A, page 26).

2. On August 29, 2023, the Department received a prior authorization request submitted on Petitioner's behalf for (1) a light wheelchair and accessories, including a back cushion; and (2) a gel pressure mattress. (Exhibit A, pages 16-17, 55-56).

3. The Department then assigned each request a separate tracking number. (Exhibit A, pages 16-18).

4. When notifying Petitioner in writing of the separate tracking numbers, the Department also requested additional information from Petitioner, including an evaluation completed within the last 90 days regarding Petitioner's medical needs, including the need for a wheelchair back cushion. (Exhibit A, pages 16-18).

5. On September 20, 2023, the Department received documentation and another prior authorization request submitted on Petitioner's behalf for (1) a light wheelchair and accessories, including a back cushion; and (2) a gel pressure mattress. (Exhibit A, pages 21-33, 59-70).

6. On September 28, 2023, the Department sent Petitioner written notice that the request for a light wheelchair with accessories was denied. (Exhibit A, pages 19-20).

7. With respect to the reason for the denial, the notice stated in part:

> The policy this denial is based on is Section 1.6, 1.8 and 2.47 of the Medical Supplier chapter of the Medical Provider Manual. Specifically:
>
> - The required documentation was not received. Please refer to prior authorization 1001014317 for the required documentation.
> - The required documentation for the prior authorization if a wheelchair including an MSA-1656 and NSA-1656 Addendum A completed within the last 90 days by an occupational therapist, physical therapist, physiatrist or rehab RN was not received. When a K0003 is requested with accessories requiring prior authorization, such as the E2611, the K0003 also requires prior authorization and the above documentation.
> - The medical need for the wheelchair back cushion was no substantiated.
> - Please refer to the Medicaid Supplier Chapter, Sections 1.6, 1.8, and 2.47
>
> *Exhibit A, pages 19-20*

8. On October 6, 2023, the Department sent Petitioner written notice that the request for a gel pressure mattress had been denied. (Exhibit A, pages 57-58).

9. With respect to the reason for the denial, the notice stated in part:

> The policy this denial is based on is Section 2.39 of the Medical Supplier chapter of the Medicaid Provider Manual. Specifically:
>
> - The documentation does not contain the required information for the requested gel support surface as specified in Medicaid policy, see section 2.39 of The Medical Supplier Chapter.
> - Please resubmit a new PA with documentation less than 30 days old containing:
> - Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers,
> - Diagnosis/medical condition related to need for the item,
> - Regular assessment by a nurse, physician, or other licensed healthcare practitioner,
> - Appropriate turning and positioning schedule.
> - Wound care (for a Stage II, III or IV ulcer),
> - Management of moisture/incontinence,
> - Wound size, stage and location (for a Stage II, III or IV ulcer),
> - Nutritional assessment and intervention consistent with the plan of care.
>
> *Exhibit A, pages 57-58*

10. On November 1, 2023, Petitioner enrolled with a Managed Care Organization. (Testimony of Petitioner's representative).

11. On November 17, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this case. (Exhibit A, pages 8-14).

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, with respect to medical necessity, prior authorization request and the items requested here, the applicable version of the MPM states in part:

> **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.
>
> 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.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

* * *

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.

* * *

2.39 SUPPORT SERVICES – GROUP 1

Definition	Pressure Reducing Support Surfaces – Group 1 includes, but is not limited to, alternating pressure pad and pump; water, air, or dry pressure mattresses; or gel or gel-like pressure pads. A Group 1 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 1 mattress overlay or mattress may be covered if one of the following applies. The beneficiary: ▪ Is completely immobile (i.e., cannot make changes in body position without assistance). ▪ Has limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure) with the presence of at least one of these additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or

	➢ Compromised circulatory status. ▪ Has any stage pressure ulcer on the trunk or pelvis with the presence of at least one of these additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers ▪ Diagnosis/medical condition related to need for the item. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of

	moisture/incontinence. ▪ Wound size, stage and location (for a Stage II, III or IV ulcer). ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is not required for HCPCS codes A4640, E0184, E0185, E0186, E0187 or E0197 if the Standards of Coverage are met and one of the following diagnoses is present: ▪ Alteration of Consciousness, Coma or Transient Alteration of Awareness ▪ Anoxic Brain Damage ▪ Anterior Horn Cell Disease ▪ Cerebral Degenerations Usually Manifested in Childhood ▪ Cerebral Edema ▪ Compression of Brain ▪ Congenital or Hereditary Progressive Muscular Dystrophy, Myotonic Disorders, Familial Periodic Paralysis ▪ Decubitus Ulcer ▪ Encephalophy, Unspecified ▪ Fracture of the Cervical or Dorsal Areas (open or closed)

	▪ Hemiplegia and Hemiparesis ▪ Huntington's Chorea ▪ Infantile Cerebral Palsy ▪ Multiple Sclerosis ▪ Neurofibromatosis ▪ Other Congenital Anomalies of Nervous System ▪ Other Demyelinating Disease of Central Nervous System ▪ Other Paralytic Syndromes ▪ Parkinson's Disease ▪ Spina Bifida ▪ Spinocerebellar Disease PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ All other diagnoses. ▪ Replacement in less than three years.
Payment Rules	A Group 1 support surface may be a capped rental or purchase depending on the specific HCPCS code. Only a single Group 1 support surface will be considered for a purchase/rental at any given time. If unit is billed as a capped rental, the rental payment would be inclusive of the following:

	▪ All accessories needed to use the equipment (e.g., pump, pad, cards etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

* * *

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS

2.47.A. DEFINITIONS

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.
Pediatric Mobility Device	Pediatric mobility products are pediatric-sized mobility and positioning medical devices (as defined by PDAC) that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems designed specifically for children with special needs. These products must meet the definition of Durable Medical Equipment (DME) (refer to the Program

	Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative.
Licensed Medical Professional	A licensed medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier. Medicaid policy requires that assessments must be performed by a licensed medical professional. A physical therapy assistant (PTA) or a licensed occupational therapy assistant (OTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.
Pediatric Subspecialist	A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.
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.
Community Residential Setting	A community residential setting is defined as a non-institutional setting in the community, i.e., beneficiary's own home, Adult Foster Care (AFC), Assisted Living or Group Home.

2.47.B. STANDARDS OF COVERAGE

Manual Wheelchair in Community Residential Setting	May be covered if **all** of the following are met: ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute with or without an assistive medical device. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury. ▪ Purchase of a wheelchair is required for long-term use (greater than 10 months). ▪ Must be able to use the wheelchair in the home environment (e.g., wheelchair must be able to fit through doorways and cross thresholds) ▪ Must identify other economic alternatives considered. ▪ Must have a method to propel wheelchair, which may include: ➢ Ability to self-propel for at least 60 feet over

	hard, smooth, or carpeted surfaces. ➢ The beneficiary has a willing and able caregiver to push the chair if needed. In addition: A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required. A **standard light-weight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance. A **heavy-duty standard wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. (Include patient's weight in the beneficiary's file.) An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. (Include patient's weight in the beneficiary's file.) A **high-strength light-weight or ultra-light standard wheelchair** may be covered when required for a specific functional need. A **back-up or secondary standard manual wheelchair** may be considered when:

	▪ The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.
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.
Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings	May be covered if the beneficiary meets **all** of the following: ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals. ▪ Requires use of a wheelchair for at least four hours throughout the day. ▪ Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate. ▪ Has a cognitive, functional level that permits safe operation of a power mobility device with or without training. ▪ Has visual acuity that permits safe operation of a power mobility device. ▪ For a three-wheeled power mobility device, has sufficient trunk control and

	balance.
Pediatric Mobility Devices and Wheelchairs	May be covered if **all** of the following are met for each type of device. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries. **For manual pediatric wheelchairs:** ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without an assistive medical device or has a willing and able caregiver to push the chair **and** the wheelchair is required in a community residential setting. ▪ Is required for long-term use (greater than 10 months). ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. ▪ Is designed to be transportable. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs.

	For power wheelchairs: ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces (this includes the need to rest at intervals). ▪ Is able to safely control the wheelchair through doorways and over thresholds up to 1½". ▪ Has a cognitive, functional level that is adequate for power wheelchair mobility. ▪ Has visual acuity that permits safe operation of a power mobility device. ▪ Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width. ▪ For a three-wheeled power mobility device, has sufficient trunk control and balance. **For transport mobility medical devices (e.g., strollers):** ▪ Is over three years of age or has a medical condition that cannot be accommodated by commercial products.

	▪ Will be the primary mobility device due to inability to self-propel a manual wheelchair or operate a power wheelchair. ▪ Is required as a transport device when the primary wheelchair cannot be designed to be transportable. ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. ▪ Is required for use in the community residential setting. **For pediatric standing systems with or without wheels:** ▪ Is able to utilize the product without being compromised medically or functionally. ▪ Has a plan of care that documents how the standing system will be used in the community residential setting. ▪ Documentation addresses economic alternatives, including dynamic vs. non-dynamic factors. ▪ Other economic alternatives

	have been ineffective. ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries. **For pediatric hi/low chairs:** ▪ Positioning cannot be accommodated by use of other mobility devices or commercial products. ▪ Is required for independent transfers. ▪ All mobility products with interchangeable bases and seating systems have been ruled out as economic alternatives. ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.
Standard Seating System in Community Residential Setting	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. ▪ 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. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.
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. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

Manual or Power Recline Feature	May be covered when needed for relief of pressure on the seat and/or back, and one of the following applies: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Has ability to tolerate a 90-135 degree range of motion at the hip, needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved. A low shear recline back is covered when the beneficiary does not have the ability to reposition themselves in the wheelchair following reclining and the shearing would result in skin breakdown.
Manual Tilt-in-Space or Recline Function in Community Residential Setting	**Manual tilt-in-space** function allows the seat and back of the wheelchair to move as a unit, such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not

	affect the hip-to-knee angle. The seat may be tilted manually. --- The **tilt-in-space** function for a wheelchair may be covered if **one or more** of the following apply: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective. State reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and a custom-molded seating system. Coverage of both a **manual tilt-in-space and recline function** for a wheelchair requires medical need (such as high probability of the development of hip contractures) if only a tilt-in-

	space without recline is used. Also, there is a medical contraindication to using recline-only without the tilt-in-space function.
Power Tilt-in-Space or Recline Function in Both Community Residential and Institutional Residential Settings	**Power tilt-in-space or recline** function may be covered if **all** of the following exist: ▪ An existing medical condition results in the inability to reposition self without the use of a power tilt or recline mechanism. ▪ The frequency of repositioning is clinically indicated and is an integral part of the nursing facility plan of care. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and there are regular periods of time that the beneficiary is without assistance. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and is able to independently care for himself when provided a power tilt-in-space or recline modification. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also

	reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.
Wheelchair Accessories	Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific wheelchair accessory codes when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or an addition to an existing wheelchair if: ▪ It is required to provide safety. ▪ It is required for appropriate positioning. ▪ It is the most economical alternative. For additions to an existing wheelchair, the physician or the occupational or physical therapist must address the status/condition of the current wheelchair and include the brand, model, serial number, and age of the current wheelchair. If MDHHS did not purchase the wheelchair being modified, all documentation requirements must be provided as if the request is for a new or initial wheelchair. Refer to the Non-Covered Items section of this chapter for information on accessories that are not covered.

2.47.C. PRIOR AUTHORIZATION FOR PURCHASE, RENTALS, REPAIRS, AND/OR REPLACEMENT OF MOBILITY DEVICES

Prior Authorization	The Medicaid Utilization Analyst (Program Review Division) is the authorized Medicaid representative who determines if the service requested falls within the standards of coverage. A prior authorization request may be returned or denied if the documentation is incomplete and not specific to the beneficiary and device requested. MDHHS reserves the right to request additional documentation to determine medical necessity. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries. For beneficiaries in the community residential setting, the decision notice is sent to the medical supplier with a copy to the beneficiary. For beneficiaries in the institutional residential setting, the decision notice is sent to the institutional residence with a copy to the beneficiary.

	Prior authorization is required for: ▪ Power wheelchairs, power-operated vehicles, seating, and accessories. ▪ New and replacement custom-fabricated seating systems, and the addition of functions for tilt-in-space and/or recline (power or manual). ▪ Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items. ▪ Replacement of standard wheelchairs beyond established timeframes. Standard wheelchairs with specified accessories/add-ons do not require prior authorization if the Standards of Coverage and Documentation requirements are met. Consult the Medicaid Code and Rate Reference tool and the Wheelchair/Power-Operated Mobility Accessory Reimbursement document on the MDHHS website for accessories/add-on items that require prior authorization and/or are included in the wheelchair base. (Refer to the Directory Appendix for website information.)
Clinical Documentation	The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the evaluation

	was completed. Clinical documentation must include how the requested seating or mobility device is the most appropriate to assist in performing MRADL. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

MPM, July 1, 2023 version
Medical Supplier Chapter, pages 9-10, 13-15, 98-100, 108-114

Here, as discussed above, Respondent denied Petitioner's requests for (1) a light wheelchair and accessories, including a back cushion;, and (2) a gel pressure mattress.

In appealing the denials, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the 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 that burden of proof with respect to either prior authorization request, and both of the Department's decisions must therefore be affirmed.

Regarding the request for a light wheelchair and accessories, Ms. Wixtrom credibly explained that a prior authorization was required for the entire request as at least one of the requested accessories, *i.e.,* the wheelchair back cushion, required prior authorization.

She also testified that, as explained in both the above policy and initial letter requesting additional information, that prior authorization must include specific documentation, including an evaluation and clinical documentation completed by a licensed medical professional within the previous ninety days and substantiating the medical need for the back cushion.

She further testified that both requests for a light wheelchair and accessories failed to include that documentation, with the only support provided for a back cushion being a prescription for the cushion and a conclusory statement that Petitioner will use one, and that the prior authorizations requests therefore could not be approved, with the Department requesting additional information in response to the first request and denying the second request.

In response, Petitioner's representative testified that the whole process has been overwhelming and that they relied on the medical professionals and suppliers to take care of the request, with Petitioner and his representative providing anything asked of them. He also questioned why the Department did not approve the rest of the request for a light wheelchair and accessories while denying the request for a back cushion.

Petitioner's representative's testimony that they relied upon the medical professionals and supplier is certainly credible, and the undersigned Administrative Law Judge understands that position. However. he is limited to reviewing the Department's decision in light of what was requested, in its entirety, and what was submitted to the Department, regardless of what Petitioner and his representative provided to the facility of the medical supplier. Moreover, as the submitted documentation in this case was insufficient to meet all the requirements for the requested light wheelchair and all accessories, the Department's decision was proper and must be affirmed.

Regarding the request for a gel pressure mattress, Ms. London credibly testified that, while the above policy does not require prior authorization for pressure reducing support surfaces like gel pressure mattresses where there is a diagnosis of hemiplegia and hemiparesis, as is the case here, a prior authorization was still submitted here; it therefore had to be reviewed under the applicable standards of coverage and documentation requirements; and those requirements were not met given the lack of both specific information found in the request regarding certain standards of coverage and documentation within the preceding thirty days addressing all listed areas.

In response, Petitioner's representative testified that it is mind-boggling that the prior authorization was submitted when it was not even required, and that it was denied under the same circumstances. However, he also failed to demonstrate that all the applicable standards of coverage or documentation requirements were met.

The undersigned Administrative Law Judge appreciates Petitioner's representative's frustration with the fact that a prior authorization was submitted when one was not required, especially given that Petitioner has since moved to a Managed Care Organization and will have to work through them in the future. However, the undersigned Administrative Law Judge is also required to review the Department's decision in the case with respect to the prior authorization that was submitted; and, as demonstrated by the Department and undisputed by Petitioner, the prior authorization request in this case failed to meet all applicable criteria and, consequently, had to be denied.

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 requests.

IT IS THEREFORE ORDERED that:

The Department's decisions are **AFFIRMED.**

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 12th day of January 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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