[redacted]
[redacted] MI [redacted]

Date Mailed: August 9, 2024
MOAHR Docket No.: 24-007828
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 Petitioner's request for a hearing.

After due notice, a hearing was held on August 7, 2024. [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf. Allison Pool, Appeals Review Officer, appeared on behalf of Respondent, Michigan Department of Health and Human Services (Respondent, MDHHS or Department). Adam Schlaufman, Utilization Analyst, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for a 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 Medicaid beneficiary, who has been diagnosed with Angelman syndrome. (Exhibit A, p 16; Testimony).

2. On April 25, 2024, the Department received a prior authorization request for a wheelchair for Petitioner. (Exhibit A, pp 11-28; Testimony).

3. On May 17, 2024, the Department sent Petitioner a Notification of Denial indicating that the manual wheelchair was denied. Specifically, the notice indicated:

    - The documentation indicates the same brand, model, and size of wheelchair as what is currently owned by the beneficiary is being requested as a second wheelchair for use in another

caregiver's home. The request to provide duplicate equipment is denied.

- A second wheelchair for beneficiary preference or convenience is not covered.

****

- Refer to the Medical Supplier Chapter, Sections: 1.6, 1.8, 1.11, and 2.47.

(Exhibit A, pp 8-9; Testimony).

4. On June 20, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, pp 7-10).

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:

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, [*sic*] 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.

****

1.6.A PRESCRIPTION REQUIREMENTS

****

MDHHS reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

****

1.8 PRIOR AUTHORIZATION

****

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:

****

- New equipment when current equipment can be modified to accommodate growth

****

- Second wheelchair for beneficiary preference or convenience

Medicaid Provider Manual
Medical Supplier Chapter
April 1, 2024, pp 9-11, 13, 25-27
Emphasis added

With regard to manual wheelchairs, the MPM provides, in pertinent part:

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.

Medicaid Provider Manual
Medical Supplier Chapter
April 1, 2024, p 109

Here, the Department sent Petitioner written notice that the prior authorization request for a second wheelchair was denied on the basis that Petitioner already owns the same wheelchair as requested.

The Department's witness reviewed evidence demonstrating that the wheelchair being requested was the same wheelchair Petitioner already owns. (See Exhibit A, pp 11, 16, 19, 21, 23.)

Petitioner's mother testified that Petitioner is now [redacted] years old and she and Petitioner's father are divorced. Petitioner's mother indicated that Petitioner goes to a special needs school and it is difficult to transfer her back and forth to school and to her ex-husband's home with the one wheelchair. Petitioner's mother noted that Petitioner struggles very much with walking.

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 is limited to reviewing the Department's decision in light of the information that was available at the time the decision was made.

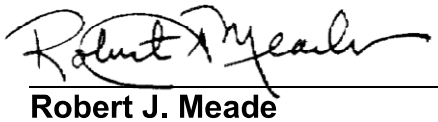
Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that the Department's decision must therefore be affirmed. Policy clearly states that a second wheelchair for preference or convenience is not covered under Medicaid. Here, Petitioner is seeking a second wheelchair of the same kind she currently owns so it can be left at Petitioner's father's house, since the parties are now divorced and living separately. Medicaid will not cover a second wheelchair for such a purpose.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied Petitioner's prior authorization request for a wheelchair.

IT IS THEREFORE ORDERED THAT:

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



RM/sj

Robert J. Meade
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

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 9th day of August 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

Agency Representative
Allison Pool
MDHHS Appeals Section
Lansing, MI 48909
PoolA@michigan.gov

DHHS Department Contact
Gretchen Backer
MDHHS
Lansing, MI 48909
MDHHS-PRD-Hearings@michigan.gov

DHHS Department Representative
Mary Carrier
MDHHS Appeals Section
Lansing, MI 48909
MDHHS-Appeals@michigan.gov

Via First Class Mail:

Authorized Hearing Representative
[redacted]
[redacted] MI [redacted]

Petitioner
[redacted]
[redacted] MI [redacted]