

ISSUE

Did the Department properly deny Petitioner's request for prior authorization of manual wheelchair?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a Medicaid beneficiary, who has been diagnosed with a spastic quadriplegic cerebral palsy. (Exhibit A; Testimony.)
2. In January 2025, Respondent approved Petitioner for a power wheelchair as the primary mobility device for independent mobility in the home and community. (Exhibit A; Testimony.)
3. On December 2, 2025, Respondent received a Prior Authorization for a manual wheelchair and accessories. (Exhibit A; Testimony.)
4. On December 4, 2025, Respondent issued a Notification of Denial Request for Administrative Hearing. The notice indicated the request for manual wheelchair was denied under sections 1.6, 1.11, and 2.4 of the Medical Supplier Chapter of the Medicaid Provider Manual. (Exhibit A; Testimony.)
5. On December 17, 2025, Respondent received a Prior Authorization for a manual wheelchair and accessories. (Exhibit A; Testimony.)
6. On January 12, 2026, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing regarding the manual wheelchair denial. (Exhibit A.)
7. On or around January 16, 2026, Respondent issued a Notice of Amended Authorization, approving a power wheelchair for Petitioner. (Exhibit A; Testimony.)

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 statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The Medicaid Provider Manual provides, in pertinent part, as follows:

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.

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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.

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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 (added per bulletin MSA 19-10) NP or PA. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDHHS standards of coverage

Medical equipment may be determined to be medically necessary when all of the following apply:

- The service/device meets applicable federal and state laws, rules, regulations, and MDHHS promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- The safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.
- The function of the service/device:
 - meets accepted medical standards, practices and guidelines related to:
 - type,
 - frequency, and
 - duration of treatment; and

- is within scope of current medical practice.
- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device is ordered by the treating physician, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.
- The service/device meets the standards of coverage published by MDHHS.
- It meets the definition of Durable Medical Equipment (DME) as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications

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1.11 NONCOVERED ITEMS

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

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- Equipment for social or recreational purposes
- Second wheelchair for beneficiary preference or convenience¹

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The question before the tribunal is whether the documentation submitted with the prior authorization request for a manual tilt-in-space wheelchair satisfied the medical necessity and coverage requirements of the Michigan Medicaid Provider Manual, particularly §§1.6, 1.11, and 2.48. The Department's denial rested on its determination that the request did not contain the clinical detail needed to establish medical necessity for a second wheelchair in addition to the power wheelchair already approved earlier in 2025. The record supports this determination.

¹ MPM, Medical Supplier Section, October 1, 2025, pp 1, 8, 10-11, 27-28.

Under §1.6, Medicaid requires that the medical record contain sufficient documentation of the beneficiary's medical condition, including diagnosis, functional limitations, clinical course, prognosis, and past experience with related equipment, in order to substantiate the necessity of the specific device requested and to demonstrate that it is the **least costly alternative** meeting the beneficiary's medical and functional needs. The record must also show why the requested equipment is medically appropriate and complies with MDHHS standards of coverage. The Department's witness credibly testified that the MSA-1656 and Addendum A submitted with the manual wheelchair request failed to include any discussion of the recently approved power wheelchair, including its brand, model, serial number, or age, nor did it address the clinical need for a manual wheelchair **in addition to** the existing power mobility device.

This omission is significant because §2.48 requires that when requesting additional seating or mobility equipment, the provider must identify the beneficiary's current wheelchair and explain why the requested equipment is medically necessary beyond what the current device provides. Thus, the record did not satisfy §1.6's requirement for comprehensive, item-specific medical documentation.

Because the request did not articulate why the manual wheelchair was clinically required beyond the capabilities of the existing power wheelchair, which had been approved with tilt/recline, head-array controls, attendant controls, specialized seating, and was documented for use in home, community, and school settings, MDHHS reasonably viewed the request as asking for a **second wheelchair** without demonstrated medical necessity. Under §1.11, Medicaid does not cover a second wheelchair that is requested for "beneficiary preference or convenience," and the absence of documentation explaining a medical rationale for dual devices meant the request fell within this noncoverage category.

The Department's witness testified that, based on the materials submitted, the documentation did not address medical necessity for a second device at all, and, therefore, defaulted to noncoverage under §1.11.

Petitioner argued that environmental barriers, including Michigan's winter conditions, inaccessible community locations, and expected repair periods, make the manual chair a necessary backup device. However, the admitted clinical record submitted with the prior authorization request contained no therapist documentation or clinical analysis identifying the specific circumstances in which the power wheelchair could not safely or effectively be used, nor explaining why a manual wheelchair was the medically necessary and least-cost solution in those situations. This absence of clinical justification is critical because the power wheelchair approval documents in Exhibit A show that the device was already prescribed for community use and included features such as a slim turning radius, all-wheel suspension, obstacle-climbing capability, and an attendant control system intended to address environmental and safety concerns. Without clinician-supported findings contrasting the capabilities of the power chair with the asserted environmental limitations, the requirements of §1.6 and §2.48 were not met.

Petitioner also asserted that loaner equipment provided during repairs would not replicate the beneficiary's highly customized seating system, causing periods of immobility. While the Department acknowledged the provider's duty under the Provider Manual to supply loaner equipment during servicing, the witness explained that repair needs alone do not justify coverage of a second wheelchair unless the documentation specifically demonstrates why a second device is medically necessary rather than a matter of convenience. The prior authorization request included no such documentation. The Department's testimony further reflected that no evidence had been submitted showing either that the provider had failed in its loaner-equipment obligations or that the beneficiary's clinical needs could not be safely met by an appropriately configured loaner unit.

Finally, Petitioner pointed to the beneficiary's IPOS goals related to community participation, independence, and engagement as demonstrating the need for two mobility devices. However, the IPOS itself was not admitted into evidence, and the Manual requires that medical necessity be established through clinical documentation specific to the requested equipment, not through general habilitation goals. Section 1.6 explicitly states that neither a prescription nor a general statement of need is sufficient; the provider must submit medical documentation showing why the specific device is the most appropriate and economical alternative. Because no such documentation was included for the manual wheelchair request, MDHHS correctly applied §§1.6, 1.11, and 2.48 in determining the request was insufficient.

In sum, the evidence shows that Petitioner did not meet the burden of proof. The Department's denial was consistent with the governing Medicaid coverage policies and supported by the record demonstrating that the request lacked the required clinical detail necessary to establish medical necessity for a second wheelchair in addition to the already approved and well-documented power wheelchair.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Petitioner's request for a second wheelchair based on the submitted documentation.

IT IS THEREFORE ORDERED that:

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