

**Date Mailed:** March 3, 2026

**Docket No.:** 26-002421

**Case No.:** [REDACTED]

**Petitioner:** [REDACTED]

**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 February 24, 2026. [REDACTED] Petitioner, appeared on her own behalf. Leigha Klaver, Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Chris Wickstrom, Analyst, testified as a witness for the Department.

**Exhibits:**

Petitioner	None
Respondent	A – Hearing Summary

**ISSUE**

Did the Department properly deny Petitioner’s prior authorization request for wheelchair repairs?

**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 low back pain and spondylosis without myelopathy or radiculopathy. (Exhibit A).
2. On November 24, 2025, Petitioner received a Notice of Denial of Medical Coverage denying a request for wheel chair repairs. (Exhibit A; Testimony.)
3. On December 31, 2025, Respondent received a prior authorization from National Seating and Mobility for a wheelchair repair. (Exhibit A; Testimony.)
4. On January 7, 2026, Respondent sent Petitioner a Notification of Denial, denying the requested wheelchair repair. The notice indicated the denial was based on sections 1.6 and 19 of the Medical Supplier Chapter found in the Medicaid Provider Manual. (Exhibit A; Testimony.)

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5. On January 27, 2026, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit A.)

## **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 supplies, 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:

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- 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 [*sic*] 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.

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- 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.

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### **1.9.C. REPAIRS AND REPLACEMENT PARTS**

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDHHS purchased the item. If MDHHS did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from

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service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply loaner equipment while the beneficiary-owned item is being serviced at no charge to MDHHS. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDHHS will consider reimbursement for a replacement when it is more costly to repair and replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

The repair and/or replacement of CRT equipment and accessories is limited to DME providers that are enrolled with Medicaid as a CRT provider. Non-CRT providers are approved on a case-by-case basis when an enrolled CRT provider is not available in the beneficiary's geographic location. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.<sup>1</sup>

Based on the record presented, the Petitioner bears the burden of proving that the Department acted contrary to law or policy in denying the request for repairs. The Department relied on several policy provisions contained in the Michigan Medicaid Provider Manual, including Section 1.6, which requires that the beneficiary's medical record contain sufficient documentation substantiating the medical necessity of the requested repair and confirming that the device represents the most appropriate, economical alternative. The Department also relied on policy that provides the Department requires medical necessity and supporting documentation to approve repairs.

The evidence shows the Department requested documentation from the provider demonstrating that the Medicare appeal process had been exhausted, which was not provided, and further that Medicare had denied coverage because the request was not medically necessary.

Petitioner argued that both the scooter repairs and shroud are medically necessary because the scooter was required for daily functioning and the shroud protects mechanical and electrical components from environmental destruction.

Accordingly, based on the governing policies, Medicare's non-coverage determination, the absence of the required supporting documentation, and the Petitioner's failure to provide evidence substantiating the medical necessity of the shroud and repairs, the

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<sup>1</sup> MPM, Medical Supplier, January 1, 2026, pp 10-11, 23.

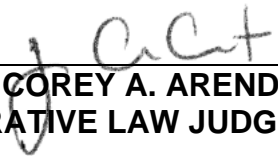
Petitioner has failed to meet their burden. For these reasons, the Department's denial of the prior authorization request for repairs is upheld.

**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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**COREY A. ARENDT**  
**ADMINISTRATIVE LAW JUDGE**

**APPEAL RIGHTS:** Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at [courts.michigan.gov](http://courts.michigan.gov). The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at <https://irs.michbar.org> or Michigan Legal Help at <https://michiganlegalhelp.org>. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to [MOAHR-BSD-Support@michigan.gov](mailto:MOAHR-BSD-Support@michigan.gov), **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to  
Michigan Office of Administrative Hearings and Rules  
Rehearing/Reconsideration Request  
P.O. Box 30639  
Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.



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