STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 1, 2019
[redacted]
AGENCY: MAP
FH #: 7920061N

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on March 25, 2019, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Centers Plan for Healthy Living

Debbie Ferguson, Fair Hearing Representative

ISSUE

Was Centers Plan for Healthy Living's determination to deny the Appellant's request for a motorized wheelchair is correct?

FACT FINDINGS

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 42, has been in receipt of Medical Assistance through Centers Plan for Healthy Living.

2. On November 1, 2018, Centers Plan for Healthy Living received the Appellant's request for prior approval for a motorized wheelchair for Appellant.

3. On November 13, 2018, Centers Plan for Healthy Living determined to deny the Appellant's request for prior approval for a motorized wheelchair because "it was not medically necessary."

4. The Appellant requested an internal appeal and on November 26, 2018, Centers Plan for Healthy Living upheld the prior denial as per a "Centers Plan for Healthy Living Appeal Decision Letter".

5. On March 1, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

2. "Medical Assistance" shall mean payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title, and the regulations.

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap.

18 NYCRR 513.1 provides the following definition of medical necessity:

(c) Necessary to prevent, diagnose, correct or cure a condition means that requested medical, dental and remedial care, services or supplies would: meet the recipient's medical needs; reduce the recipient's physical or mental disability; restore the recipient to his or her best possible functional level; or improve the recipient's capacity for normal activity. Necessity to prevent, diagnose, correct or cure a condition must be determined in light of the recipient's specific circumstances and the recipient's functional capacity to use or make use of the requested care, services or supplies and appropriate alternatives.

Public Health Law Section 4403-f provides in pertinent part as follows concerning eligibility for managed long term care:

1. Definitions. As used in this section:

(a) "Managed long-term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long-term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

(c) "Operating demonstration" means he following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long-term care services" means services including, but not limited to home and community-based and institution-based long-term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long-term care plan may also cover primary care and acute care if so authorized.

7. Program oversight and administration

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services"' in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be

made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP- "Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

The Durable Medical Equipment Procedure Codes and Coverage Manual states as follows, starting on Page 47:

WHEELED MOBILITY EQUIPMENT (WME), SEATING AND POSITIONING COMPONENTS (SPC)
General Clinical Criteria for Wheeled Mobility Equipment:
 The term wheeled mobility equipment (WME) describes manual wheelchairs (MWC), power mobility devices (PMD) including power wheelchairs (PWC), power operated vehicles (POV) and push rim activated power assist devices (PAD).
 Wheeled mobility equipment is covered if the beneficiary's medical condition(s) and mobility limitation(s) are such that without the use of the WME, the beneficiary's ability to perform mobility related activities of daily living (MRADL) in the home and/or community is significantly impaired and the beneficiary is not ambulatory or functionally ambulatory.
When a beneficiary presents for a medical evaluation for WME and SPC (Seating and Positioning Components), the sequential consideration of the questions below by ordering and treating practitioners provides clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform MRADLs. MRADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan completed in customary locations in the home and community.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs? A mobility limitation is one that:
(a). Prevents the beneficiary from accomplishing the MRADLs entirely, or,

(b). Places the beneficiary at a reasonably determined heightened risk of morbidity or mortality secondary to attempts to participate in MRADLs, or,
(c). Prevents the beneficiary from completing the MRADLs within a reasonable time frame.

2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs?
(a). Some examples are significant impairment of cognition or judgment and/or vision.
(b). For these beneficiaries, the provision of WME and SPC might not enable them to participate in MRADLs if the co-morbidity prevents
effective use of the wheelchair or reasonable completion of the tasks even with WME and SPC.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of WME and SPC will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs?
(a). A caregiver, for example a family member, may be compensatory, if consistently available and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
(b). If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of WME and SPC coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of WME and SPC.

4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the WME and SPC safely and independently?
(a). Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
(b). A history of unsafe behavior may be considered.

5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
(a). The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
(b). Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of WME and SPC?
(a). Determine whether the beneficiary's environment will support the use of these types of WME and SPC.

(b). Keep in mind such factors as physical layout, surfaces, and obstacles, which may render WME and SPC unusable.

7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating and positioning components, wheelbase, device weight, and other appropriate accessories) for this determination.
(a). Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
(b). A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
(c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
(d). Assess the beneficiary's ability to safely use a manual wheelchair.
NOTE: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.
8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
(a). A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC (a 3-wheeled device is not covered).
(b). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
(c). Assess the beneficiary's ability to safely use a POV/scooter.

9. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more MRADLs?
(a). The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
(b). The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
(c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
(d). **Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.**
NOTE: If the beneficiary is unable to use a power wheelchair or power SPC and if there is a caregiver who is available, willing and able to provide assistance, a manual wheelchair and manual SPC is appropriate.
Go to http://www.cms.hhs.gov/determinationprocess/downloads/id143c.pdf for a flow chart developed by the Medicare program that visually describes the clinical criteria for the evaluation and ordering of WME.

General Coverage Criteria for WME:

 The coverage criteria for Medicaid reimbursement of WME is based on a stepwise progression of medical necessity listed in the clinical criteria above and the specific criteria in this section
 In order for these criteria to be met, the beneficiary must have an evaluation that was performed by a qualified practitioner who has specific training and/or experience in wheelchair evaluation and ordering.
 The practitioner must document, to the extent required by the coverage criteria for the specific WME, how the beneficiary's medical condition supports Medicaid reimbursement.
 The practitioner must have no financial relationship with the supplier.
 If coverage criteria for the WME that is requested or provided are not met and if there is another device that meets the beneficiary's medical needs, payment will be based on the allowance for the least costly medically appropriate alternative.
 Determination of least costly alternatives will take into account the beneficiary's weight, seating needs, amount and type of use and needs for other medically necessary features.
Maintaining documentation of least costly alternatives reviewed and attempted is the responsibility of the ordering practitioner and DMEPOS provider.

Documentation must be submitted or provided at the time of manual review of a prior approval request, claim, or audit.

The eMedNY provider manual, pp. 55-57 also states:

4. The practitioner must document medical necessity, to the extent required by the coverage criteria for the specific WME/SPC; how the member's medical condition supports Medicaid reimbursement. The documentation must be summarized and forwarded to the supplier in the form of a qualified practitioner's letter of medical justification, an evaluation template and/or, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. The practitioner must maintain appropriate and complete medical records even if a letter of medical justification or evaluation template is provided to the supplier. Examples of medical documentation which is applicable include but are not limited to:

History:
- Symptoms
- Explain history of decubitus/skin breakdown, if applicable
- How long the condition has been present.
- Clinical progression
- Interventions that have been tried and the results
- Past use of walker, manual wheelchair, POV, or power wheelchair and the results

●A list of all current WME and SPC (e.g., make, model, serial number, age) and an explanation of why it no longer meets the member's medical needs (suppliers must obtain cost estimates of repair of equipment).
●Reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the member.
●Describe other physical limitations or concerns (e.g., respiratory)
●Describe any recent or expected changes in medical, physical, or functional status
Physical exam:
●Related diagnoses
●Impairment of strength, range of motion, sensation, or coordination of arms and legs
●Presence of abnormal tone or deformity of arms, legs, or trunk
●Neck, trunk, and pelvic posture and flexibility
●Sitting and standing balance
●Measurements of height, weight, chest, shoulders, hips, legs
●Absent or impaired sensation in the area of contact with the seating surface
●Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.
Functional assessment:
●Describe MRADL capabilities and any problems with performing MRADLs, including the need to use a cane, walker, or the assistance of another person
●Describe activities, other than MRADLs, performed while in wheelchair
●Transferring between a bed, chair, commode, toilet and WME
●Walking around customary environment – provide information on distance walked, speed, and balance.
●Ability to carry out a functional weight shift
●Describe in detail any significant postural asymmetries with applicable quantitative measurements (e.g., scoliosis leg length discrepancy).
●Describe feeding capabilities and seating modifications required to facilitate feeding capabilities
●Specifics why less costly alternatives are not medically appropriate based on the member's medical needs.
Plan of Care:
●Intended use and amount of time daily the equipment is used and, degree of ambulation in customary environment
●What MRADLs will the member participate in with the new WME and SPC
●A narration of medical necessity for the WME and SPC, describing what medical needs specific to the member will be met if the equipment is provided.
●An estimate of how long the equipment will be needed
●If surgery is anticipated, indicate the CPT Procedure code(s) and ICD Diagnosis code(s) and expected surgery date.
●Describe anticipated modifications or changes to the equipment within the next three years
●Describe the growth potential of the requested equipment in number of years
●For SPC, describe whether it can be integrated into a new or existing wheelchair

5. For beneficiaries who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 or Group 4 PWC, or a push-rim activated power assist device, the evaluation must provide detailed information explaining why each specific option or accessory is needed to address the member's mobility limitation.
6. Prior to or at the time of delivery of a POV or PWC, the supplier, practitioner, or case manager must perform an on-site evaluation of the member's home to verify that the member can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request.

• See the following link for an example of an evaluation form template

Wheelchair and Seating Assessment Guide. This form is not a required element of the medical record or prior approval submission. Although a practitioner-completed form is considered part of the medical record, it is not a substitute for the comprehensive medical record as noted above. If only a form is provided to the supplier, the documentation, to the extent required by the coverage criteria for the specific WME/SPC, present on the form must describe how the member's medical condition supports Medicaid reimbursement.
• If the evaluation form, letter of medical justification or medical records of a licensed/certified medical professional (LCMP) (e.g., physical or occupational therapist) is to be considered as part of the medical record, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. Documentation without such an attestation will not be considered part of the medical record for prior approval or audit purposes. Documentation must contain the therapist's name and licensure, evaluation date, phone number, address and employer

The manual meanwhile states from page 58:
POWERED MOBILITY DEVICES (PMD)
Are covered when: s met for specific devices listed below.
1. The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more MRADL, and

2. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker, and

3. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.
NOTE: A PMD will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

Power Operated Vehicles (POV), 4 wheeled, are covered if all of the basic coverage criteria (1-3) for PMDs have been met and if criteria (4-9) are also met.

4. The beneficiary is able to:
(a). Safely transfer to and from a POV, and
(b). Operate the tiller steering system, and
(c). Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids

5. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home, and

6. The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and

7. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided, and Page 58 of 169
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8. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs, and

9. The beneficiary has not expressed an unwillingness to use a POV.
NOTE: Group 2 POVs have added capabilities that must be medically justified; otherwise payment will be based on the allowance for the least costly medically appropriate alternative, the comparable Group 1 POV. If coverage criteria 1-9 are met and if a beneficiary's weight can be accommodated by a POV with a lower weight capacity than the POV that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.
Accessories
Reimbursement price for all POV includes:
Battery or batteries required for operation
Battery charger single mode
Weight appropriate upholstery and seating system
Tiller steering
Non-expandable controller with proportional response to input
Complete set of tires
All accessories needed for safe operation
(The above parts may not be billed separately with a new POV.)

Partially capitated Managed Long-Term Care Plans do not cover all medical care and services required by enrollees. However, pursuant to Appendix G of the partial capitation Managed Long-Term Care Model Contract, durable medical equipment is to be covered by the MLTC Plan where medically necessary.

Pursuant to State policy, Medicaid standards will govern determinations to authorize or not authorize covered services under MLTC.

Pursuant to GIS Message 13 MA/015, issued on July 19, 2013, at a fair hearing to review the district's denial of a Medicaid application, the Medicaid applicant has the burden of proving that the district's denial was incorrect. When the applicant prevails, the fair hearing decision will reverse the denial. The district cannot deny the application based on the reason that was set forth in the agency's denial that was reversed. If no remaining eligibility factors need to be considered, the district must find the applicant eligible for Medicaid. When a fair hearing decision reverses the denial of a Medicaid application and one or more remaining eligibility factors need to be considered, the district must continue to process the application and issue a decision as soon as possible. In such cases, the applicant's original application date must be preserved.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Section 358-5.9 of the Regulations provide in part:

> (a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes that the Appellant, age 42, receives care and services through Centers Plan for Healthy Living. The Appellant requested Centers Plan for Healthy Living's prior approval for a motorized wheel chair and by notice dated November 13, 2018, Centers Plan for Healthy Living determined to deny the Appellant's request for prior approval for a motorized wheelchair because it was not medically necessary.

The record establishes that Centers Plan for Healthy Living based its determination on an August 27, 2018, letter Appellant testified to submitting in support of his request for the

motorized wheel chair. The letter indicated that the Appellant suffers from poliomyelitis which causes loss of muscles in lower extremity……..and requests for home health assistance for the Appellant; which request is not at issue at this hearing.

At the hearing, the Appellant testified that he made the request personally, because he needs the motorized wheel chair to enable him to go outside; to the park, for doctor's appointments, grocery shopping, and to move around easily inside of his home. When asked at the hearing about his manual wheel chair, the Appellant further testified that his hand muscles are getting tired as he gets older, and would prefer to use the motorized wheel chair. The Appellant further testified that he did not submit any physician letter and or any other medical documentation in support of his request for the motorized wheel chair.

The Appellant's testimony was considered, but it was not found to be sufficiently persuasive to establish that Centers Plan for Healthy Living's denial of assistance was not correct. The eMedNY Durable Medical Equipment Manual states on page 58, that POWERED MOBILITY DEVICES (PMD) are covered when: "The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories." It noted that Appellant using his manual wheel chair transported himself from the waiting area into the hearing room. The Appellant failed to establish that he is not ambulatory or not functionally ambulatory using the manual wheel chair. Therefore, Centers Plan for Healthy Living's determination must be sustained based on the weight of the evidence submitted at the hearing.

DECISION AND ORDER

Centers Plan for Healthy Living's determination to deny the Appellant's request for a motorized wheelchair is correct.

DATED: Albany, New York
04/17/2019

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee