STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-49418 TRN
Case No. [redacted]

Appellant
_____/

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 the Appellant's request for a hearing.

After due notice, a hearing was convened [redacted]. It was continued on behalf of the Appellant, who could not proceed on the telephone longer due to the cost per minute of air time. The hearing was reconvened [redacted], with the Appellant appearing in person at his local DHS office. The Appellant represented himself.

[redacted], Appeals Review Officer, represented the Department. [redacted] Eligibility Specialist, appeared as a witness for the Department of Human Services (DHS). [redacted] appeared as a witness on behalf of the Department when the hearing was reconvened.

ISSUE

1. Did the Department properly fail to provide the Appellant written Notice he was denied reimbursement for medical transportation?

2. Did the Department properly deny the Appellant's request for medical transportation?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary. (uncontested)

2. The Appellant is dependent upon R.S.D.I. of approximately [redacted] per month from the Social Security Administration. (Department Exhibit B, page 6)

3. The Appellant resides in [redacted], which is located in [redacted] County. (uncontested)

4. [redacted] has a population of approximately [redacted]. (U.S. Census data from 2000)

5. [redacted] is approximately [redacted] miles from [redacted], Michigan, where the Appellant's preferred doctor has an office. (Department Exhibit A, page 11)

6. The Appellant has requested medical transportation reimbursement from the Department of Human Services and been reimbursed in the past for at least 2 trips. (Department Exhibit A)

7. The Appellant requested reimbursement forms for medical transportation from his DHS worker and was verbally informed he could not have reimbursement for medical transportation outside of his community. No forms were provided for medical reimbursement after [redacted]. (testimony of Appellant and Department Witness)

8. The Appellant was advised by his DHS worker that he could seek medical treatment from a doctor located in his home town, thus had no need for reimbursement of medical transportation. (uncontested testimony from the Appellant)

9. The Appellant has an established doctor/patient relationship with his treating physician for his medical condition in [redacted]. (uncontested)

10. The Appellant continued to treat with his doctor of choice when possible after the [redacted] verbal denial of transportation services.

11. The Appellant asserts he is unable to treat as often as recommended and as often as he would like due to the inability to meet the expense associated with travel to and from the doctor's office.

12. At hearing, the Department conceded the Appellant could have been informed that he would not get reimbursed for medical transportation due to the local office position that the doctor is outside of his community. It was further conceded his denial could have been verbal rather than in writing. (testimony of Department Supervisor and worker)

13. On [redacted], the Appellant requested a formal administrative hearing. The Department seeks dismissal of the hearing request because it is asserted the request was not made within 90 days from the last time a written request for medical travel reimbursement was made.

CONCLUSIONS OF LAW

The Medicaid program was established pursuant to Title XIX of the Social Security Act (SSA) and is implemented by 42 USC 1396 *et seq*., and Title 42 of the Code of Federal Regulations (42 CFR 430 *et seq*.). The program is administered in accordance with state statute, the Social Welfare Act (MCL 400.1 *et seq*.), various portions of Michigan's Administrative Code (1979 AC, R 400.1101 *et seq*.), and the State Plan promulgated pursuant to Title XIX of the SSA.

The medical transportation coverage under the State Medicaid Plan is set forth in Bridges Administrative Manual (BAM). The pertinent portions are below:

> **MEDICAL TRANSPORTATION**
>
> You must furnish information in writing and orally, as appropriate, to all applicants and to all other individuals who request it acknowledging that medical transportation is **ensured** for transportation to and from medical services providers for MA-covered services. MDCH Publication 141, Medicaid Health Care Coverage, may be used to provide written information. Payment for medical transportation may be authorized only after it has been determined that it is not otherwise available, and then for the least expensive available means suitable to the client's needs.
>
> Medical transportation is available to:
> - FIP recipients.
> - MA recipients.
> - SSI recipients.
>
> **Note:** DCH authorized transportation is limited for clients enrolled in managed care. See **CLIENTS IN MANAGED CARE.**
>
> Medical transportation is not available to the following, unless it is to obtain medical evidence; see BAM 815:
> - FIP applicants.
> - SDA applicants/recipients.
> - MA applicants.
> - AMP applicants/recipients (BEM 640).
> - FAP applicants/recipients (BEM 230B).

- Clients who have not met their deductible.
- Medicare Savings Program only (BEM 165) recipients.
- QDWI (BEM 169) recipients.
- Recipients limited to emergency MA coverage.

NON-EMERGENCY MEDICAL TRANSPORTATION

Medicaid Non-Emergency Medical Transportation (NEMT) Brokerage Contract in [redacted] and [redacted] Counties

The Michigan Department of Community Health has contracted with [redacted] to administer non-emergency medical transportation in [redacted] and [redacted] counties for dates of service on and after January 1, 2011.

Effective for dates of service on and after January 1, 2011, [redacted] and [redacted] DHS offices will no longer be reimbursed for Medicaid non-emergency medical transportation. All beneficiaries residing in [redacted], and [redacted] will be receiving a letter informing them of this change.

Beneficiaries who are currently receiving or need to request NEMT in the future should be referred to LogistiCare. LogistiCare may be reached at (866) 569-1902.

Reminder: In all other counties, each County DHS office is responsible for NEMT for the beneficiaries who reside in that county.

COVERED MEDICAL TRANSPORTATION Medical transportation is available to obtain medical evidence or receive any MA-covered service from any MA-enrolled provider, including:

- Chronic and ongoing treatment.
- Prescriptions.
- Medical supplies.
- Onetime, occasional and ongoing visits for medical care.

Exception: Payment may be made for transportation to V.A. hospitals and hospitals which do not charge for care (such as St. Jude Children's Hospital, Shriners Hospital).

MEDICAL TRANSPORTATION NOT COVERED

Do not authorize payment for the following:

- Transportation for noncovered services (such as AA meetings, medically unsupervised weight reduction, trips to pharmacies for reasons other than obtaining MA-covered items).
- Reimbursement for transportation for episodic medical services and pharmacy visits that has already been provided.
- Transportation costs for long-term care (LTC) residents. LTC facilities are expected to provide transportation for services outside their facilities.
- Transportation costs to meet a client's personal choice of provider for routine medical care outside the community when comparable care is available locally. Encourage clients to obtain medical care in their own community unless referred elsewhere by their local physician.
- DCH authorized transportation for clients enrolled in managed care is limited; see **CLIENTS IN MANAGED CARE.**

  Exception: Dental, substance abuse or community mental health services are not provided by managed care; therefore, an DCH authorization for medical transportation for these services may still be necessary.
- Transportation services that are billed directly to MA; see **BILLED DIRECTLY TO DCH.**

MEDICAL TRANSPORTATION EVALUATION

Evaluate a client's request for medical transportation to maximize use of existing community resources.

- If the client, or his/her family, neighbors, friends, relatives, etc. can provide transportation, they are expected to do so, **without reimbursement**. If transportation has been provided to the client at no cost, it is reasonable to expect this to continue, except in extreme circumstances or hardship.
- Do not routinely authorize payment for medical transportation. Explore why transportation is needed and all alternatives to payment.
- Do not authorize payment for transportation unless first requested by the client.

- Use referrals to public or nonprofit agencies who provide transportation to meet individual needs without reimbursement.
- Use free delivery services that are offered by a recipient's pharmacy.
- Use bus tickets or provide for other public transportation arrangements.
- Refer to volunteer services or use state vehicles to transport the client if payment for a personal vehicle is not feasible.

LOCAL OFFICE PROCEDURES

It is essential that medical transportation is administered in an equitable and consistent manner. It is important that local offices have procedures to assure medical transportation eligibility and that payment reflect policy. If such procedures do not exist, local office management is to initiate a process that supports this policy.

Transportation Coordination

It is recommended that local/district offices institute a transportation coordinator to ensure that all necessary tasks are done. This position would be responsible for establishing local procedures to assure the following:

- All requests for medical transportation are assessed and processed according to policy and local office procedures.
- Verification of current or pending MA on CIMS is available.
- The DHS-54-A, Medical Needs, is given to eligible clients when required.
- Each client's need for transportation and access to resources are appropriately assessed.
- Maximum use is made of existing community transportation resources.

  Note: Many transportation authorities will make tickets/passes available at special rates. The transportation coordinator is encouraged to negotiate with the local transit authority and develop administrative procedures for distribution to recipients. In some areas it may be cost effective for local offices to contract with local transit providers for all or part of transportation services in the local office, such as Agencies on

Aging, Intermediate School Districts, local CMHSP.

- Alternative transportation means are used.
- New resources are developed within the community, including the use of social contract participants to act as schedulers, providers or in other supportive roles related to the transportation activities of the local office.
- The Department of Community Health (DCH) is contacted for any required prior authorizations.
- Sufficient MSA-4674-S, Medical Transportation Statement, are given to eligible clients.
- A centralized process for returning completed MSA-4674-S is developed and implemented.
- The amount of reimbursement is correct, authorization for payment is completed and forwarded to the fiscal unit, and payment is processed in a timely manner.
- A local office liaison exists for resolving transportation payment disputes.

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Payment Authorization
Authorize payment for medical transportation beginning the month the client reported the need.

At application, do not authorize payment earlier than the MA begin date.

If program eligibility is denied, only authorize payment for transportation to obtain medical evidence.

Some transportation services require prior authorization. See **PRIOR AUTHORIZATION** below.

Transportation services for children and families active for child welfare services and required as part of the services care plan are authorized by services staff. See Childrens Foster Care Manual CFF 903-9, PRNon-Scheduled Payments DHS-634 for policy and procedures. Foster parents that provide medical transportation for a foster child in their care may receive mileage reimbursement at the volunteer driver rate ($.328 per mile).

REVIEW
Review continued need for medical transportation:

- When indicated on the verification (DHS-54A).
- At redetermination.
- Annually for SSI recipients.

The need for a special allowance must be reviewed yearly; see **Special Allowances.** The need for transportation must be reviewed even if recipient's medical condition is considered lifetime.

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DENIAL OF REIMBURSEMENT FOR TRANSPORTATION
Use an DHS-301, Client Notice (Medical Transportation Denial), to notify a client that medical transportation is denied; see RFF. The notice contains:

- The action being taken.
- The reason(s) for the denial.
- BAM 825 as the legal base.
- The individual's right to request a hearing.
- Referring the client to the HMO for transportation services covered by the HMO; see **CLIENTS IN MANAGED CARE**.
- Referring the client to the community mental health services program for transportation covered by their capitation rates; see **CLIENTS IN MANAGED CARE**.
- Referring the client to those providers who are able to bill MA directly; see **BILLED DIRECTLY TO DCH**.

Do not issue an DHS-301 when making a referral.

Bridges Administrative Manual (BAM), 825 Medical Transportation
January 1, 2011

ISSUE I

The Department first sought to have the Appellant's request for hearing dismissed as untimely. The Department cited the fact that the hearing request had come in more than 90 days since the last written request for mileage reimbursement had been submitted to the Department. The fact that the last written request for mileage reimbursement for medical appointments was submitted more than 90 days prior to the hearing request is uncontested. However, credible, uncontested evidence was brought

forth that the Appellant had actually made request(s) for additional medical transportation reimbursements and been denied verbally. He was not provided the form the Department seeks to establish an appropriate timeline for determining whether the hearing request is timely. He was not provided written Notice he was being denied, nor informed of hearing rights in writing for the denial of the Medicaid covered service. The Department witness initially made available for hearing was neither the actual worker, nor her supervisor, however, the supervisor who did testify confirmed the local office policy of denying medical transportation to Medicaid beneficiaries who seek it for doctor visits the local office believes is outside the community. She could not establish any denial notice had been sent to this Appellant. The hearing was continued at a later date. The worker was present for the continued hearing. She said she did not have anything in writing to confirm she had denied the request for transportation reimbursement forms, however based upon her memory and instruction from supervision at the local office, she believes the Appellant's assertion is true. No evidence was presented by the worker that the Appellant was provided written Notice of denial.

This ALJ cannot grant a dismissal for lack of timeliness with these circumstances. There is no recognition in Medicaid policy of verbal Notice, nor was any authority cited to recognize such a concept. No authority was cited for disregarding the requirement of mailing written Notice to Medicaid beneficiaries who have been denied a Medicaid covered service. The Department is required to provide written Notice to Medicaid beneficiaries when a covered service is reduced, terminated or denied. Here the substantial, credible evidence of record can be relied on to find the Appellant was denied the medical transportation service he sought and he was not provided written notice of the denial. The Department's own witness stated she believed the Appellant's assertion he had been verbally informed he would not be provided the transportation service he sought was true. This ALJ does find the claim credible and relies on the testimony of both the Appellant and the Department witnesses to make this finding. The Department seeks to start the 90 day count down from the last time a reimbursement form was received. The 90 day time frame for requesting a hearing begins when the Notice is mailed. Because the Department has, to date, failed to provide proper Notice of the denial to the Appellant regarding his request, his hearing request is timely. The Department's request for dismissal is denied.

ISSUE II

The Department witness did testify that the Appellant's transportation request was denied because the Appellant has chosen a physician located outside his community. The Department asserts the denial is supported by Policy. The local office has determined that [redacted] is outside his community. It is stipulated the distance between the Appellant's residence and his preferred provider is approximately [redacted] miles (each way). The Appellant resides in a rural community of approximately 1200 people. While there is testimony that [redacted] does have at least 1 doctor and that in the past the Appellant had sought medical treatment from a doctor in [redacted], these

facts alone are inadequate to establish an enrolled Medicaid provider located [redacted] miles away is outside of the community. Furthermore, the care being sought must be comparable care. This ALJ will briefly address this aspect of the policy below, although detailed findings are not necessary in this case because the distance being traveled to obtain medical treatment in this case is not far by any reasonable measure.

This ALJ did inquire of the Department witness [redacted] how the Department did determine what constitutes the Appellant's community. The witness responded "prior records establish he had seen a doctor in the [redacted] area." This is not responsive to the question asked, thus it was restated as, "is it unusual to drive to a doctor in [redacted]?" She responded, "there are physicians in [redacted]." This ALJ asked if it unusual another time and received this response, "yes, based on his situation of limited income and resources." This is an explicit assertion that the Appellant's medical choices must be defined by his resources and circumstances. The frank understanding of what the Department is asserting in this case is, bluntly stated, if he cannot afford to drive himself to his doctor he should find one closer. Medicaid benefits include transportation reimbursement when necessary to access medically necessary care for Medicaid covered services. It does not require a beneficiary to obtain medical treatment from the closest enrolled Medicaid provider. While the policy enacted by the Department encourages the beneficiary to obtain medical treatment nearby if possible, Medicaid policy does not support limiting the transportation benefit to only the closest provider. Traveling [redacted] miles each direction to obtain medical treatment is not on its face "outside of the community." This finding is supported by the Department transportation policy itself which requires an exception be sought in cases where travel in excess of 50 miles in each direction is requested. Additionally, for Medicaid beneficiaries enrolled in HMOs, the primary care physician is considered to be within the community if the office is 30 miles or 30 minutes away from the residence of the Medicaid beneficiary. This distance is used to support a determination that a beneficiary has reasonable access to care in his community. Because the transportation policy allows for reimbursement of overnight expenses and meals in certain circumstances, there is a need to make decisions that protect public money from potential abuse. This ALJ submits that the concept of "outside of his community" is intended to address circumstances different than those evidenced in this case; i.e. a beneficiary who seeks to have routine medical treatment from a primary care physician located 150 miles away. It is not an abuse of a benefit to be reimbursed for chronic, ongoing treatment [redacted] miles from home. This ALJ finds the Department's determination that a Medicaid enrolled provider located approximately [redacted] miles from the beneficiary's residence is outside of his community is an error. A denial of medical transportation reimbursement on this basis is therefore improper.

The Department's decision to deny mileage reimbursement for travel due to a determination that comparable care can be found in his community was not proper. In this case the Appellant has been treating with a provider whose letterhead indicates "[redacted] Spine and Pain." It also states it is a family practice. This ALJ does not believe Medicaid Policy would place an eligibility worker in the position of attempting to

determine where it is appropriate for a beneficiary to obtain medical treatment based upon specific, protected medical information about the beneficiary. Thus, where the policy references "comparable care," it must be interpreted reasonably, with the protections afforded in HIPPA in mind. The Department made no showing that the beneficiary was able to obtain comparable care in [redacted]. Rather, it was simply stated that there are doctors in [redacted]. However, whether the care rendered in [redacted] is comparable care or not is immaterial in this particular case because the doctor in [redacted] is located within the Appellant's community.

In this case the Appellant is a Medicaid beneficiary who asserted he has a need for reimbursement in order to obtain Medicaid covered medical treatment. In accordance with Policy, the Department of Human Services must ensure he does have access to Medical transportation if needed. The basis of their denial in this case cannot be sustained. No showing was made the Appellant does not have a need for the benefit he requested. He was unable to participate in the entire telephone hearing due to the limitation of minutes on his phone. The hearing was re-scheduled to accommodate his lack of reliable, unlimited phone use and allow him to travel into the local DHS office to participate. Accommodation was made to wait until he received a disability check that would allow him to put enough gas in his vehicle to drive to the office and participate in the hearing. There was no evidence presented in the record to refute the assertion from the Appellant that he has a financial need to access this benefit.

DECISION AND ORDER

This Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly denied the Appellant's request for medical transportation to his treating physician in [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED. The Department shall reimburse the Appellant for travel to his doctor in [redacted] for treatment rendered since the request date of [redacted].

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _10/17/2011_____

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.