STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted]

Docket No. 2013-40683 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted]. [redacted], Appellant's father, appeared on Appellant's behalf. Appellant's witnesses were [redacted], Executive Director, [redacted] County; [redacted], Family Advocate, [redacted] County; [redacted], Licensed Occupational Therapist, [redacted]; and [redacted], Advocate, CLS Aide.

[redacted], Fair Hearing Officer, [redacted] County Community Mental Health Authority (CMH), represented the Department. [redacted] Supports Coordinator; [redacted], Program Coordinator, Supervisor; and [redacted], Program Director; appeared as witnesses for the Department.

Following the hearing, the record was left open until [redacted] so that the parties could submit written closing briefs. Appellant's closing brief was received on [redacted]. Respondent's closing brief was received on [redacted].

ISSUE

1. Did the CMH properly deny Appellant's request for 10 hours per day of Community Living Supports (CLS)?

2. Did the CMH properly deny Appellant's request for 2 hours per day of Enhanced Hourly Care?

3. Did the CMH properly deny Appellant's request for a wheel chair lift and tie-downs in an adaptive vehicle or, in the alternative, enhanced transportation services?

4. Did the CMH properly deny Appellant's request for an adaptive bathtub and an overhead ceiling lift?

5. Did the CMH properly deny Appellant's request for the purchase and installation of an inclined platform lift to allow Appellant to be transported to the lower level of her home in a wheel chair?

6. Did the CMH properly deny Appellant's request for Targeted Case Management?

FINDINGS OF FACT

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

1. Appellant is a [redacted] year old Medicaid beneficiary, born [redacted], who receives services through [redacted] County Community Mental Health (CMH). (Exhibit A, p 2; Testimony)

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Since [redacted], Appellant has been receiving services through the Children's Waiver Program (CWP), a federal program that provides Medicaid funded home and community-based services to children under age [redacted] that are eligible for, and at risk of, placement into a nursing facility. (Exhibit 1, p 15; Testimony)

4. Appellant lives with her father in a single family home. Appellant's father is her primary caregiver. (Exhibit 1; p 9; Testimony).

5. Appellant is diagnosed with [redacted] syndrome, which has resulted in numerous secondary complex and debilitating medical conditions, including encephalopathy and complex partial seizures. Appellant is non-verbal and cannot gesture with her hands or otherwise convey her needs. Appellant has autonomic and circulatory instabilities, gastro-intestinal dysfunctions, lack of fine and gross motor abilities, osteoporosis, scoliosis, and kyphosis, and she is at risk for a heart condition called Long-QT. (Exhibit 1, pp 11-13; 16.1-16.45; 16.55-16.57; Testimony)

6. As of [redacted], Appellant was prescribed the medications keppra, privacid, clorazepam, carnitor, and miralax. (Exhibit 1, p 16.57)

7. On [redacted], Appellant, her father, her advocates, representatives from [redacted] County, and CMH representatives (the Person Centered Planning [PCP] team) held an Individualized Plan of Service (IPOS) meeting at Appellant's home. On [redacted], CMH sent Appellant and her father a draft Individual Plan of Service. (Exhibit 1,

pp 16.66-16.78)

8. To address and attempt to resolve issues identified by Appellant's team in the draft IPOS, the PCP team met on three more occasions: [redacted], [redacted], and [redacted], but were unable to work out their differences. (Exhibit 1, p 8; Testimony)

9. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for Specialized Medical Equipment and Supplies – Vehicle Modifications, was denied. The reason given for the denial was that the information provided by Appellant was not the most cost-effective and did not meet value purchasing standards. (Exhibit A, pp 15-16; Testimony)

10. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for 10 hours of Community Living Supports (CLS) hours per day was denied. The reason given for the denial was that the health concerns of the caregiver did not support the definition of "significant health concerns which prevent the caregiver from providing care for the child." (Exhibit A, pp 17-18)

11. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for Environmental Accessibility Adaptations for modifications to the bathroom and a lift for the basement stairway were denied. The reason given for the denial was that the CWP does not cover construction costs in a new home or addition, or in a home purchased after the beneficiary is enrolled in the waiver. (Exhibit A, pp 21-22)

12. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for 224 hours of CLS per year (in addition to the authorized 8 hours per day of CLS) was denied. The reason given for the denial was that the additional hours were not medically necessary. (Exhibit A, pp 23-24). *Since the time Appellant filed her appeal, these hours have been authorized and Appellant withdrew her appeal on this issue.* (Exhibit 1, p 4)

13. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for Targeted Case Management Services was denied. The reason given for the denial was that Targeted Case Management was not available through the CWP. (Exhibit A, pp 19-20)

14. On [redacted], CMH sent an Adequate Action Notice to Appellant, notifying her that her request for enhanced hourly care under the Children's Waiver Exception Process was denied. The reason given for the denial was that there had been no change in the family situation which was outside of the family's control that placed Appellant in jeopardy of serious injury or significant deterioration of health status. (Exhibit A, pp

25-26)

15. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 2).

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.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other

> than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve her goals.

1. The CMH properly denied Appellant's request for 10 hours per day of Community Living Supports (CLS).

The Medicaid Provider Manual, Mental Health / Substance Abuse Section, Section 14.3 Covered Waiver Services, provides with respect to Community Living Supports:

> Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community.
>
> This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

> Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.
>
> The CMHSP must maintain the following documentation:
>
> - A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.
>
> - Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.
>
> All service costs must be maintained in the child's file for audit purposes.

The CMH argues that Appellant's request for 10 CLS hours per day was denied because, according to the Children's Waiver Decision Guide, Section I – Number of Caregivers, Appellant is only entitled to receive a maximum of 8 CLS hours per day because Appellant falls under Category III and has one caregiver who does not work full-time. The CMH also argues that according to the Children's Waiver Decision Guide, Section II – Health Status of Caregivers, Appellant is only entitled to receive a maximum of 8 CLS hours per day because Appellant's caregiver has "some health concerns". Some health concerns are defined as: "one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month." (See Medicaid Provider Manual, Mental Health/Substance Abuse Section, Children's Waiver CLS Services Appendix; Exhibit A, pp 37-39).

Appellant's father argues that Appellant should be entitled to 10 CLS hours per day because Appellant's father actually has "significant health concerns", which is defined as: "one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition." (See Medicaid Provider Manual, Mental Health/Substance Abuse Section, Children's Waiver CLS Services Appendix; Exhibit A, pp 37-39). In support of his position, Appellant's father submitted a Social Security Decision which found him disabled and entitled to Social Security Disability benefits as well as information from his private disability insurance carrier. (Exhibit A, pp 20.3-20.12) Appellant's father also submitted other medical documentation, which was reviewed by the CMH.

Based on the evidence presented, the CMH properly denied Appellant's request for 10 CLS hours per day. Under the guidelines discussed above, Appellant is only entitled to 8 CLS hours per day because she falls under Category III and has one caregiver who does not work and because Appellant's father has "some health concerns", at least as

defined above. Appellant's father argues that he has a medical condition that "prevents" him from caring for his daughter, yet he is and remains Appellant's primary caregiver. Appellant's father argues that the word prevent is not adequately defined in the Medicaid Provider Manual and that his conditions do sometimes prevent him from providing care to his daughter. However, it is clear from the example used in the definition of "significant health concerns" above, (as someone in a full body cast), that Appellant's father does not meet that level of health concern. Clearly, someone in a full body cast would not be able to care for Appellant at all for any period of time, whereas Appellant's father is clearly able to care for his daughter for significant periods of time because he continues to do so.

2. The CMH properly denied Appellant's request for 2 hours per day of Enhanced Hourly Care under the Children's Waiver Exception Process.

The Medicaid Provider Manual provides, with regard to the Children's Waiver Exception Process, the following:

> **3.4 EXCEPTION PROCESS**
>
> The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise.
>
> When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.
>
> Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by the MDCH to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family centered practice team recommendation, and CMHSP administrative concurrence.
>
> The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception **and** a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/MR rules, and any enhancements must be essential to maintain the child within their home. Consideration for an exception will be limited to situations outside the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);

- A temporary inability of the primary caregivers to provide the requisite level of care (e.g., an acute illness or injury);

- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;

- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e., previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;

- Natural supports are unable to provide the requisite level of care (e.g., only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDCH can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to MDCH within 10 days; or

- In a nonemergency situation, the CMHSP provides the MDCH with written documentation of the specific rationale to support the exception (i.e., physician’s prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDCH will occur within 10 working days.

> When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDCH may request a meeting in order to clarify and reconsider the basis for the exception.
>
> MDCH has the option to request a home visit to meet the child when it is necessary for an effective decision.
>
> *MPM, Mental Health/Substance Abuse Section*
> *Children's Waiver CLS Services Appendix, pp A7-A9*

The CMH argues that Appellant is not entitled to an exception for the number of CLS hours allocated because there has been no change in the family situation which is "outside the family's control that place's the child in jeopardy of serious injury or significant deterioration of health status."

Appellant's father argues that both Appellant's condition and his condition have worsened in the past few years and that his request for an exception was based on the same factors considered above under issue #1. In his closing brief, Appellant's father also pointed out that Appellant was receiving additional CLS hours in [redacted] County under an exception because of his significant health concerns. Appellant's father argues that moving from one county to another should not change the situation.

Based on the evidence presented, the CMH properly denied Appellant's request for an exception to the number of CLS hours allocated. The evidence presented does not show a change in the family situation which is "outside the family's control that place's the child in jeopardy of serious injury or significant deterioration of health status." Furthermore, the fact that Appellant's situation may have been interpreted differently by the CMH in [redacted] County is not binding on a determination made by [redacted] County CMH.

3. The CMH improperly denied Appellant's request for a wheel chair lift and tie-downs in an adaptive vehicle or, in the alternative, enhanced transportation services.

The Medicaid Provider Manual provides, with regard to the Specialized Medical Equipment and Supplies, the following:

> Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use

> of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs.
>
> Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies.)
>
> Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented. A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase. Emphasis added.
>
> *MPM, Mental Health/Substance Abuse Section*
> *Children's Home and Community Based Services Waiver*
> *April 1, 2013, p 81*

The CMH denied Appellant's request for vehicle modifications because the information provided by Appellant was not the most cost-effective and did not meet value purchasing standards. The CMH indicated in its Adequate Action Notice that Appellant was seeking reimbursement for a new MV-1 Deluxe vehicle, costing $[redacted] or a Ford E-150 Club Wagon, costing $[redacted]. At the hearing, CMH argued that even if Appellant was not seeking reimbursement for the entire cost of a new vehicle, the cost for modifications was going to be anywhere from $[redacted] for a Chrysler Towne &

Country to $[redacted] for the MV-1. In its post-hearing brief, the CMH indicated that it would like the opportunity to provide an Occupational Therapist to assess a vehicle for Appellant, but that this would require Appellant's father to choose a vehicle first. Once CMH has access to the vehicle, it will commit to assessing it for medically necessary modifications within 30 days.

Appellant's father pointed out at the hearing that he was only seeking reimbursement for the cost of a wheel chair lift and tie downs, which are built into the vehicle he wishes to purchase, the MV-1. In the documentation Appellant provided to the CMH prior to the hearing, it clearly states that the cost for the wheelchair accessible features on the MV-1 is only $[redacted]. (Exhibit 1, p 23.16)

Based on the evidence presented, the CMH improperly denied Appellant's request for vehicle modifications, at least for the reasons stated in the Adequate Action Notice, based on the information Appellant submitted. First, the information contained in the Adequate Action Notice is in no way related to the request Appellant's father made – he never asked CMH to purchase a new vehicle, he simply asked them to commit to reimbursing him for the cost of the wheel-chair lift and tie downs in the vehicle he found would be the best fit for Appellant. Second, even at the hearing, the information put forth by the CMH was inaccurate because the documentation provided by Appellant's father clearly indicates that the cost for the wheelchair accessible features on the MV-1 is only $[redacted], not $[redacted] as the CMH argued.

This is not to say that the CMH must reimburse Appellant for the cost for the wheelchair accessible features on the MV-1; it is only to say that the CMH's decision cannot be supported based on the evidence in this record because the reasons cited for the denial in the Adequate Action Notice do not correlate to Appellant's request as evidenced by the information provided by Appellant prior to the denial.

Within 10 days of the date of this Decision, the CMH must initiate work with Appellant's father to assess a vehicle for modifications to fit Appellant's needs under the standards outlined in the Medicaid Provider Manual. "Initiate" means contacting Appellant's father to begin the process of scheduling an occupational therapist to assess a vehicle; it does not mean competing the assessment or approving any modifications within 10 days.

Given the above decision, Appellant's request for enhanced transportation services, in lieu of vehicle modifications, will not be considered.

4. The CMH improperly denied Appellant's request for an adaptive bathtub and an overhead ceiling lift.

The Medicaid Provider Manual provides, with regard to the Environmental Accessibility Adaptations, the following:

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment.

Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home.

All work must be completed while the child is enrolled in the CWP. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDCH are not obligated for any restoration costs.

If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.

Additional square footage may be prior authorized following a MDCH specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.

MPM, Mental Health/Substance Abuse Section
Children's Home and Community Based Services Waiver
April 1, 2013, pp 79-80

The CMH denied Appellant's request for an adaptive bathtub and an overhead ceiling lift because it determined that the CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the CWP. The CMH reasoned that because Appellant's home was purchased while Appellant was receiving CWP services, it was the family's responsibility to assure that the home met the child's basic needs.

Appellant's father argues that he was never asking CMH to pay for "construction" – he is only asking for an adaptive bathtub and an overhead ceiling lift. Appellant's father indicated that he is and has always been willing to pay for the costs of construction, including any plumbing or electrical work that might need to be done to install the tub and the lift. Appellant's father pointed out that the need for both the adaptive bathtub and ceiling lift was determined to be medically necessary by the PCP team and the need was included in Appellant's IPOS. Appellant's father also pointed out that the Children's Waiver only requires that he purchase a home with a bathroom that would be generally accessible to Appellant, such as one on the first floor. The bathroom on the home he purchased is on the first floor.

Based on the evidence presented, the CMH improperly denied Appellant's request for an adaptive bathtub and an over-head ceiling lift, at least for the reasons stated in the Adequate Action Notice. Appellant's father met his responsibilities under the Children's Waiver by purchasing a home with a first floor bathroom that will be generally accessible to Appellant. He was under no obligation to purchase a home that already contained an adaptive tub and an overhead lift and, in all likelihood; he would not have been able to find a home with such adaptations already included.

Within 10 days of the date of this Decision, the CMH must initiate working with Appellant's father to assess Appellant's bathroom for any medically necessary modifications. "Initiate" means contacting Appellant's father and beginning the process of scheduling an occupational therapist to assess the bathroom; it does not mean competing the assessment and approving any modifications within 10 days. The CMH is welcome to use the assessment Appellant's father had prepared by [redacted], but it is not required to rely on this assessment.

5. The CMH properly denied Appellant's request for the purchase and installation of an inclined platform lift to allow Appellant to be transported to the lower level of her home in a wheel chair.

The CMH denied Appellant's request for an inclined platform lift to allow Appellant to be transported to the basement because it determined that the CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CMH reasoned that because Appellant's home was purchased while the child was receiving waiver services, it was the family's responsibility to assure that the home met the child's basic needs. CMH argued at the hearing that it did not approve the inclined platform lift to allow Appellant to be

transported into the basement because Appellant had no need to go into the basement and all of her needs could be met in the rest of the home, to which she already has access.

Appellant's father argued that Appellant needs access to the basement because the basement is the safest place to be in case of an emergency and because Appellant could do her physical therapy down there.

Based on the evidence presented, the CMH properly denied Appellant's request for an inclined platform lift. Appellant's stated reasons for needing to go into the basement are not persuasive. There are other interior rooms in the home where Appellant can go in case of emergency, as well as other places where Appellant can do her physical therapy. It does not appear that the inclined platform lift to the basement is of direct medical or remedial benefit to Appellant.

6. The CMH properly denied Appellant's request for Targeted Case Management.

The CMH argued that Appellant's request for Targeted Case Management was denied because, under the Choice Voucher for Children – 2012 guidelines, a responsible parent of a child in the CWP can use choice voucher arrangements for all Medicaid state plan services except for targeted case management and private duty nursing. The CMH pointed out that Appellant does have a choice voucher arrangement with the CMH, so she would not be entitled to Targeted Case Management.

Appellant's father argued that he had never requested Targeted Case Management; he had simply requested that the CMH provide a new supports coordinator for Appellant. Appellant's father was advised at the hearing that if he has an issue with Appellant's supports coordinator that would be a recipient's rights issue, not an issue for a Medicaid Fair Hearing. In his closing brief, Appellant's father also raised several issues regarding the choice voucher arrangement he has with the CMH, including the fact that the CMH does not have vouchered therapy services.

Based on the information provided, the CMH properly denied Appellant Targeted Case Management. Appellant does have a choice voucher arrangement with the CMH, so she would not be entitled to Targeted Case Management. If Appellant's father has an issue with Appellant's supports coordinator, he can bring it up in a recipient's rights complaint. In addition, any issue Appellant's father has with the choice voucher arrangement generally would need to be addressed through a recipient's rights complaint because those issues do not amount to a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *42 CFR 438.400.* The choice voucher arrangement (self-determination) is not a Medicaid covered service, it is simply one means for implementing and paying for Medicaid covered services. Appellant's services are still intact and she continues to be enrolled in the program. As such, the CMH has taken no action giving rise to the right to a Medicaid fair hearing as it relates to Appellant's choice voucher arrangement.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

- The CMH properly denied Appellant's request for 10 CLS hours per day.
- The CMH properly denied Appellant's request for an exception to the number of CLS hours allocated.
- The CMH improperly denied Appellant's request for vehicle modifications based on the information Appellant submitted.
- The CMH improperly denied Appellant's request for an adaptive bathtub and an over-head ceiling lift.
- The CMH properly denied Appellant's request for an inclined platform lift.
- The CMH properly denied Appellant's request for Targeted Case Management. The issues Appellant's father has with the choice voucher arrangement do not give rise to a Medicaid fair hearing.

IT IS THEREFORE ORDERED that:

- The CMH's decision to deny Appellant's request for 10 CLS hours per day is AFFIRMED.
- The CMH's decision to deny Appellant's request for an exception to the number of CLS hours allocated is AFFIRMED.
- The CMH's decision to deny Appellant's request for vehicle modifications, at least for the reasons stated in the Adequate Action Notice, is REVERSED.
    - Within 10 days of the date of this Decision, the CMH must initiate work with Appellant's father to assess a vehicle for modifications to fit Appellant's needs under the standards outlined in the Medicaid Provider Manual.
    - "Initiate" means contacting Appellant's father to begin the process of scheduling an occupational therapist or other professional to assess a vehicle.
- The CMH's decision to deny Appellant's request for an adaptive bathtub and an over-head ceiling lift, at least for the reasons stated in the Adequate Action Notice, is REVERSED.

- Within 10 days of the date of this Decision, the CMH must initiate working with Appellant's father to assess Appellant's bathroom for any medically necessary modifications.

- "Initiate" means contacting Appellant's father and beginning the process of scheduling an occupational therapist or other professional to assess the bathroom.

- The CMH's decision to deny Appellant's request for an inclined platform lift is AFFIRMED.

- The CMH's decision to deny Appellant's request for Targeted Case Management is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]

cc: [redacted]

Date Signed: July 1, 2013

Date Mailed: July 1, 2013

***** 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.