

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

██████████

Appellant

Docket No. 2013-57216 CMH  
Case No. ██████████

**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 held on ██████████. ██████████, mother and Guardian, represented Appellant. ██████████, Manager, ██████████, appeared as a witness for Appellant. ██████████, Fair Hearing Officer, represented Respondent, ██████████ (CMH or Department). Gail Goldsmith, Case Manager, appeared as a witness for the CMH.

**ISSUE**

Did the Department properly deny the Appellant's request for a bladder scanner?

**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 ██████-year-old Medicaid beneficiary, born ██████████, who is diagnosed with Aicardi Goutieres Syndrome, cerebral palsy, mental retardation, brain atrophy, hypertonicity of legs and arms, seizure disorder, glaucoma, partial IgG deficiency, neurogenic bladder and urinary tract infections. (Exhibit A, Attachment D)
2. On ██████████, Appellant's mother first requested a bladder scanner for Appellant from the CMH. (Exhibit A, Attachment A)
3. On ██████████, Appellant's mother met with Appellant's Case Manager to further discuss the process for obtaining a bladder scanner for Appellant. (Exhibit A, Attachment B)

4. On ██████████, Appellant's mother again met with Appellant's Case Manager regarding the process for obtaining a bladder scanner. Appellant's mother was asked to sign a release so that the Case Manager could speak with the bladder scanner sales representative. (Exhibit A, Attachment C)
5. Also on ██████████, Appellant's Case Manager completed an Addendum to Appellant's Plan of Service. The addendum included, under the headings "Health" and "Natural Supports", Appellant's mother's request for a bladder scanner. Emphasis added. (Exhibit A, Attachment D)
6. Nowhere in the Plan of Service is the bladder scanner listed as an objective, a goal, or an approved device. (Exhibit A, Attachment D)
7. On ██████████, the CMH issued an Adequate Action Notice informing Appellant's mother that her request for a bladder scanner for Appellant had been denied. The reason for the denial was, "Purchase of Bladder Scanner was denied due to the device being a physical health (medical) care need, not adaptive equipment. (Exhibit A, Attachment E)
8. On ██████████, the Michigan Administrative Hearing System received the hearing request filed on the Appellant's behalf. (Exhibit 1)

### **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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

The applicable sections of the Medicaid Provider Manual (MPM) provide:

## **2.5 MEDICAL NECESSITY CRITERIA**

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

### **2.5.A. MEDICAL NECESSITY CRITERIA**

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

### **2.5.B. DETERMINATION CRITERIA**

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service. Emphasis added.

### **2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP**

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

#### **2.5.D. PIHP DECISIONS**

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

*Medicaid Provider Manual  
Mental Health & Substance Abuse Chapter  
July 1, 2013, pp 12-14*

### **SECTION 3 – COVERED SERVICES**

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the

Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended. Emphasis added.

\* \* \* \*

### **3.9 HEALTH SERVICES**

Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under Assessments subsection above. A registered nurse, nurse practitioner, physician's assistant, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP. Emphasis added.

\* \* \* \*

*Medicaid Provider Manual  
Mental Health & Substance Abuse Chapter  
July 1, 2013, pp 15, 17*

## **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process. Emphasis added.

\* \* \* \*

### **Enhanced Medical Equipment and Supplies**

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies). All enhanced medical equipment and supplies must be specified in the plan of service, and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. Emphasis added.

- Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage.
- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.
- The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription as

defined in the General Information Section of this chapter. An order is valid one year from the date it was signed. This coverage includes:

- Adaptations to vehicles;
- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items; and
- Durable and non-durable medical equipment not available under the Medicaid state plan. Emphasis added.

Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included.

Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individual Education Plan and are not covered. Eyeglasses, hearing aids, and dentures are not covered.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost

effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.

*Medicaid Provider Manual*  
*Mental Health & Substance Abuse Chapter*  
*July 1, 2013, pp 88, 90-91*

The CMH Fair Hearing Officer testified that the bladder scanner requested by Appellant's mother was denied because it is medical equipment covered under Appellant's Medicaid Health Plan (MHP) and, therefore, not something covered by CMH. The CMH Fair Hearing Officer testified that Appellant has an appeal pending for a prior authorization of a bladder scanner through his MHP and that the decision in that matter is still outstanding. The CMH Fair Hearing Officer also indicated that nowhere in Appellant's Plan of Service (POS) is a bladder scanner listed as a goal, an objective, or an approved device; rather the POS simply makes reference to Appellant's mother's request for a bladder scanner. The CMH Fair Hearing Officer testified that the bladder scanner is covered under the State Plan and Appellant's MHP – it was just denied through those programs because they did not believe it was suitable for use in the home.

Appellant's case manager testified that she had several discussions with Appellant's mother regarding a bladder scanner for Appellant but that she never added a bladder scanner to Appellant's POS as an objective, a goal or an approved device.

Appellant's mother testified that she needs a bladder scanner for Appellant because she does not know when to catheterize Appellant, which results in frequent and sometimes unnecessary catheterizations. Appellant's mother testified that Medicaid initially denied her prior authorization for a bladder scanner and that she is currently appealing that decision. Appellant's mother testified that she believes the bladder scanner is in Appellant's POS. Appellant's mother testified that the bladder scanner is cost effective because Appellant has been in the hospital 5 times in the past year, partially due to urinary tract infections (UTI's), and that the cost of one night in the hospital is approximately the same as the cost of the bladder scanner. Appellant's mother also testified that she believed the bladder scanner can be covered by CMH under the Enhanced Medical Equipment section of the Habilitation and Supports Waiver (Hab Waiver).

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The ██████████ Manager for the company that sells bladder scanners testified that a bladder scanner is able to be used in a home setting. (This was the issue in Appellant's prior authorization appeal of the denial of a bladder scanner through Appellant's MHP). The ██████████ Manager indicated that the use of a bladder scanner will prevent unnecessary catheterizations of Appellant, which will prevent Appellant's frequent urinary tract infections (UTI's). The ██████████ Manager testified that a bladder scanner would improve the quality of life for both Appellant and his mother/caregiver.

Based on the evidence presented, Appellant did not prove, by a preponderance of the evidence, that the requested bladder scanner is a covered device through CMH. As indicated above, "the PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide." Furthermore, as also indicated above, "Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP." Here, a bladder scanner is medical equipment that is covered through the State Plan and Appellant's MHP. While Appellant's MHP may have denied the bladder scanner because they did not believe that it is appropriate for home use, that does not mean that the bladder scanner is "not covered" by the MHP or that it then should be covered by CMH. Appellant has appealed the denial of the bladder scanner through her MHP and is awaiting a decision in that case.

Given the above, Appellant's argument that the bladder scanner is covered under the Habilitation and Supports Waiver through CMH is without merit. While it could be argued that a bladder scanner is "enhanced medical equipment" under the Habilitation and Supports Waiver, the bladder scanner cannot be covered by CMH under any heading because it is already covered through Appellant's MHP. As indicated above, "Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances." Here, the bladder scanner is available through regular Medicaid coverage and other insurances so it is cannot be covered as enhanced medical equipment.

Accordingly, the Department's denial of the requested bladder scanner must be upheld.

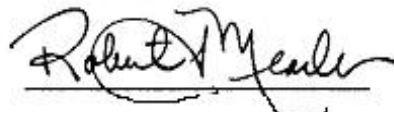
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**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for a bladder scanner.

**IT IS THEREFORE ORDERED** that:

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



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

[REDACTED]  
Date Signed: 9/5/2013

Date Mailed: 9/5/2013

cc: [REDACTED]

**\*\*\* 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.