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:

Docket No. 2014-35750 CMH

[redacted] [redacted] [redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted], Appellant's father, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf. [redacted], Manager of Due Process, represented Respondent [redacted] County Community Mental Health (the "CMH"). [redacted], Compliance Coordinator; [redacted], Supports Coordinator Supervisor; and [redacted], Occupational Therapist; from the [redacted] testified as witnesses for Respondent.

ISSUE

Did the CMH properly deny Appellant's request for mini-van accommodations when approving Appellant's request for a van lift?

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

2. In turn, the CMH contracts with service providers such as the [redacted].

3. Appellant is a [redacted] year-old Medicaid beneficiary who has been diagnosed with cerebral palsy, schizophrenia, and left-sided hemiparesis; and who has been receiving services from the CMH and [redacted] through [redacted]

Habilitation/Supports Waiver (HSW). (Petitioner's Exhibit 3, page 2; Petitioner's Exhibit 4, page 1; Respondent's Exhibit C, page 3).

4. Due to Appellant's medical conditions, she uses a wheelchair and is dependent on others for mobility and positioning. (Petitioner's Exhibit 3, page 7).

5. Appellant also requires the use of a van lift to be transported anywhere and, in the past, she has been transported through the use of a mini-van adapted to include a van lift. (Petitioner's Exhibit 3, page 7).

6. However, the van lift and mini-van Appellant utilized in the past has become worn down and is in need of replacement. (Petitioner's Exhibit 3, page 7; Testimony of Appellant's representative).

7. Accordingly, in [redacted] Appellant and her representative decided to purchase a new mini-van themselves. (Testimony of Appellant's representative).

8. They also requested that [redacted] and the CMH provide a van lift and the costs of adapting the mini-van to accommodate that van lift. (Testimony of Appellant's representative).

9. In response, [redacted] and the CMH determined that they would cover the van lift, but the approval would only be in the dollar amount for a full-sized van and the extra expenses related to mini-van accommodations were denied. (Testimony of [redacted]

10. Appellant appealed that decision to the Michigan Administrative Hearing System (MAHS); an administrative hearing was held; and a decision and order was issued affirming the CMH's decision.

11. On [redacted], Appellant submitted another request to [redacted] for funding to modify a mini-van to accommodate a van lift, along with some new supporting documentation and price quotes. (Petitioner's Exhibits 2-7).

12. As part of that supporting documentation, Appellant provided a Psychiatric Nursing Evaluation, dated [redacted], in which it was noted that Appellant responds negatively to increased noise (Petitioner's Exhibit 3, page 2), and a Skilled Nurse Visit Documentation, dated March 6, 2014, noting:

> [Appellant] stated that she is more calmer and better able to control her anxiety and the voices if she is in a smaller vehicle with less

> noise and less moving back and forth due to having to sit in her motorized chair.
>
> *Petitioner's Exhibit 3, page 5*

13. Appellant also provided an addendum, dated [redacted], from the occupational therapist regarding an earlier report he made:

> As an addendum to the initial evaluation it should be documented that due to [redacted] poor trunk strength, tolerance to static and dynamic sitting balance required during transportation tasks, a more appropriate sized minivan would benefit and reduce the stressors that this individual experiences.
>
> *Petitioner's Exhibit 3, page 11*

14. Appellant further provided a letter from her primary care physician dated [redacted] and stating:

> Several of [redacted] conditions indicate the need for an adaptive minivan rather than a full-sized van. April's poor core muscle tone (see attached occupational therapy report) requires the smoother, low profile, car-like suspension of a minivan. Full sized vans with their high stiff truck-like suspensions tend to toss her around, tipping her from side to side, as she lacks the core muscle tone to remain stable and upright, even with normal road conditions. Such jostling, as well as increased noise levels of a full sized van, also irritates the symptoms of her schizophrenia. [redacted] is mostly able to control the symptoms of her condition when her environment is reasonable quiet and still. If she must regularly be transported in a vehicle that is noisy and bumpier due to poor suspension, she will experience increased symptoms of her schizophrenia, reducing her ability to participate in the community.
>
> *Petitioner's Exhibit 4, page 1*

15. On [redacted] sent Appellant written notice that, while the funding for a basic van lift was approved, the extra expenses related to accommodating a mini-van was again denied. (Respondent's Exhibit A, pages 1-2).

16. On [redacted], the Michigan Administrative Hearing System (MAHS) received a request for hearing in this matter. (Petitioner's Exhibit 1, page 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*

Moreover, 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.

Here, as discussed above, Appellant has been receiving services through the CMH and [redacted] pursuant to Michigan's Habilitation/Supports Waiver (HSW). With respect to the HSW, the applicable version of the Michigan Medicaid Provider Manual (MPM) states:

> 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.
>
> HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:
>
> - Has a developmental disability (as defined by Michigan law);
> - Is Medicaid-eligible;
> - Is residing in a community setting;
> - If not for HSW services, would require ICF/MR level of care services; and

- Chooses to participate in the HSW in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

MPM, April 1, 2014 version
Mental Health/Substance Abuse Chapter, page 88

Appellant and her representative now seek a new van lift for a mini-van that they will purchase. They also seek to have the mini-van adapted so that it could use the van lift. In response to that request, the CMH is only willing to authorize funding for a basic van lift and will not approve the extra expenses related to accommodating a mini-van.

Both sides therefore agree that the van lift itself is covered by the HSW and should be approved. Moreover, the MPM also identifies vehicle modifications/adaptions as

covered assistive technology in provisions relating to both the HSW specifically and mental health services in general. For example, regarding the HSW supports and services of "Enhanced Medical Equipment and Supplies", the MPM provides:

> 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.
>
> - 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.

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.
>
> *MPM, April 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 90-91*

Similarly, the B3 support and services potentially available to Appellant includes assistive technology such as adaptations to vehicles:

> **17.3 B3 SUPPORTS AND SERVICES**
>
> The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.
>
> **17.3.A. ASSISTIVE TECHNOLOGY**
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> Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.
>
> Coverage includes:
>
> - Adaptations to vehicles
> - Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
> - Communication devices

- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)

- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions

- Ancillary supplies and equipment necessary for proper functioning of assistive technology items

- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.

- Items that are considered family recreational choices.

- The purchase or lease of a vehicle, and any repairs or routine maintenance to the vehicle.

- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

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.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that

> the assistive technology continues to meet the criteria for B3 supports and services as well as those in this subsection. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that 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.
>
> *MPM, April 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, pages 112-114*

However, the above sections of the MPM do not resolve the issue in this case, unlike the section of the MPM regarding with the Children's Home and Community Based Services Waiver Program (CWP), which specifically addresses vehicle modifications authorized pursuant to that program and expressly states that, while van lifts may be approved for either full-size vans or mini-vans, the program does not cover any additional costs in adapting lifts to mini-vans: "Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift." MPM, April 1, 2014 version, Mental Health/Substance Abuse Chapter, page 85. There is no similar provision with respect to vehicle modifications through the HSW.

Accordingly, the parties limit their dispute to whether it is medically necessary for Appellant to use a mini-van. With respect to medical necessity, the MPM provides:

> **2.5 MEDICAL NECESSITY CRITERIA**
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> 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;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

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;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- 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.

MPM, April 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 12-14

In arguing that the CMH erred and that it is medically necessary for the van lift to be added to a mini-van, Appellant and her representative bear the burden of proving by a preponderance of the evidence that the CMH erred. Moreover, in deciding the issue in dispute, this Administrative Law Judge's jurisdiction is limited to reviewing the CMH's decision in light of the information it had at the time it made that decision.

Here, the CMH denied the request on the basis that adapting a full-size van, along with the use of calming techniques and a proper fitting for Appellant's wheelchair, constitutes a more appropriate and cost-effective way of meeting Appellant's medical needs. In particular, [redacted] testified that she reviewed Appellant's person-centered plan, along with the evidence submitted along with the request in this case, and noted that Appellant's family has never identified loud noises or excessive movement as a trigger for crisis in the past. Nor were there any documented incidents or plan goals related to such issues. [redacted] also testified that, to the extent loud noises during transportation do cause stress or anxiety, Appellant can use the same calming techniques she usually does, such as listening to music on headphones, to distract and redirect herself. Similarly, any exacerbation of symptoms caused by excessive movement can be addressed through properly tying Appellant's wheelchair down and a proper fitting or adjustment of Appellant's wheelchair. As noted by [redacted], Appellant's occupational therapist's recommendation related to a need for better trunk control and, while he stated that a mini-van would benefit Appellant, that need can be addressed in other ways.

In response, Appellant's representative argues that, as opined by both the occupational therapist and Appellant's doctor, adapting the van lift to a mini-van is necessary in this case because the increased movement and noise caused by a full-sized van would increase Appellant's stressors and the symptoms of her schizophrenia, which would in turn reduce Appellant's ability to participate in the community. Appellant's representative also testified that incidents of anxiety are so common for Appellant that they are not documented and that Appellant does best with as smooth and as quiet a ride as possible. He further testified that the less costly alternatives identified by the CMH would be helpful if Appellant rode in a full-size van, but that they would be even more helpful if Appellant rode in a mini-van.

However, even if adapting a mini-van might be more beneficial than adapting a full-size van, Appellant and her representative have failed to meet their burden of proving that adapting the van lift to a mini-van is medically necessary, as opposed to just beneficial. Respondent's witness described less costly alternatives, including adjustments to the fitting of Appellant's wheelchair and calming techniques that have worked in the past, that could meet Appellant's needs while she rides in a full-size van. Moreover, while Appellant's representative testified that those alternatives may prove to be insufficient, that testimony, as well as the opinions of both the occupational therapist and Appellant's primary care physician, is too speculative to establish medical necessity in this case. There is no evidence regarding any specific incidents involving Appellant or goals in her person-centered plan related to loud noises or excessive movement; and it has been years since Appellant last rode in a full-sized van. Also, the alternatives and techniques identified by Respondent have not been tried or been found to be unsuccessful. Accordingly, for the reasons discussed above, the undersigned Administrative Law Judge finds that Appellant and her representative have failed to meet their burden of proof and, consequently, the CMH's decision must be affirmed.

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 mini-van accommodations when approving Appellant's request for a van lift.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

_____

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

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

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.