

**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. 2014-9220 CMH

██████████

██████████

██████████

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 the request for a hearing filed by Appellant/Petitioner.

After due notice, a hearing was held on ██████████, Appellant's father, appeared and testified on Appellant's behalf. Appellant also testified on her own behalf. ██████████, attorney and Due Process Hearings Coordinator, represented Respondent ██████████ Community Mental Health (the "CMH"). ██████████, Supports Coordinator Supervisor; ██████████, Director of Social Work/Supports Coordinator; and ██████████, Compliance Coordinator; 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 ██████████ ██████████") to provide Medicaid covered services.

██████████
Docket No. 2014-9220 CMH
Decision and Order

3. Appellant has been receiving services from the CMH and ██████████ through Michigan's Habilitation/Supports Waiver (HSW). (Respondent's Exhibit G, page 1).
4. Appellant is a ██████-year-old female who has been diagnosed with psychosis NOS; mild mental retardation; congenital diplegia; cerebrovascular anomaly; cerebrovascular accident; schizoaffective disorder; and cerebral palsy. (Petitioner's Exhibit 2, pages 1, 7; Respondent's Exhibit G, page 2).
5. Due to Appellant's medical conditions, she uses a wheelchair and is generally dependent on others for mobility and positioning. (Petitioner's Exhibit 3, page 3).
6. In the past, Appellant has been transported through the use of a mini-van adapted to include a van lift. (Petitioner's Exhibit 2, page 5; Testimony of Appellant's representative).
7. However, in ██████████, both Appellant's Individual Plan of Service and a letter from her mother indicated that, on days where Appellant's psychological symptoms were severe, Appellant would not be transported at all as her caregivers would keep her at home and practice home hospitalization. (Respondent's Exhibit H, page 1; Respondent's Exhibit I, pages 1-4).
8. According to Appellant's representative, the van lift and the accompanying accommodations allowing the lift to be used with a mini-van were provided through the CMH and ██████████. (Testimony of Appellant's representative).
9. The CMH and ██████████ have no record or knowledge of such an approval. (Testimony of ██████████; Testimony of ██████████; Testimony of ██████████).
10. By ██████████, the mini-van and lift Appellant was using became worn down and Appellant began the process of requesting a new lift. (Petitioner's Exhibit 2, page 5; Testimony of Appellant's representative).
11. Appellant and her representative would purchase a new mini-van themselves. (Testimony of Appellant's representative).
12. As part of that process, on ██████████ ██████████ Appellant's doctor prescribed an occupational therapy (OT) evaluation. (Petitioner's Exhibit 2, page 1).
13. That OT evaluation was performed on ██████████. (Petitioner's Exhibit 2, pages 1-8).
14. After the evaluation, the occupational therapist issued a report indicating that, in order to access and use a van, Appellant needs a van ramp, power door, drop floor and center clamp. (Petitioner's Exhibit 2, pages 4-5).

Docket No. 2014-9220 CMH
Decision and Order

15. The occupational therapist also indicated that Appellant would need to sit in the front of the van because of her schizophrenia and the need to calm her down when she hears voices. (Petitioner's Exhibit 2, page 5).
16. Following that evaluation, Appellant's representative obtained [REDACTED] quotes regarding the price of requested equipment. (Respondent's Exhibit E, page 1; Testimony of Appellant's representative).
17. In each case, Appellant's representative also sought the price of modifying a mini-van to allow a lift. (Testimony of Appellant's representative).
18. Appellant's representative further attempted to seek funding from charitable organizations, but was unsuccessful. (Respondent's Exhibit E, page 1).
19. Accordingly, on or about [REDACTED], Appellant and her representative requested the van lift and mini-van modifications from the CMH and [REDACTED]. (Respondent's Exhibit E, page 2; Testimony of Appellant's representative).
20. Appellant's request was initially denied in full, but [REDACTED] subsequently contacted Appellant's representative on [REDACTED] and informed him that, while Medicaid would cover the van lift, the approval would only be in the dollar amount for a full-sized van as it was less expensive than the adaptations needed for a mini-van. (Respondent's Exhibit E, pages 2-4).
21. On [REDACTED], the CMH also sent Appellant written notice of a limited authorization. Specifically, the funding for a basic van lift was approved while the extra expenses related to mini-van accommodations were denied. (Respondent's Exhibit A, page 1).
22. After the partial denial, Appellant's father obtained a letter from Appellant's doctor dated [REDACTED] and indicating that it is medically necessary for Appellant to use an adapted mini-van rather than full-size van. (Petitioner's Exhibit 3; Respondent's Exhibit B).
23. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received a request for hearing in this matter. (Petitioner's 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).

Docket No. 2014-9220 CMH
Decision and Order

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...

**Docket No. 2014-9220 CMH
Decision and Order**

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 MORC 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.

*MPM, July 1, 2013 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 van lifts and vehicle modifications as covered assistive technology:

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

Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of

Docket No. 2014-9220 CMH
Decision and Order

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.,

**Docket No. 2014-9220 CMH
Decision and Order**

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, July 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 113-114*

That section of the MPM does not expressly 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 stating 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, July 1, 2013 version, Mental Health/Substance Abuse Chapter, page 85. There is no similar provision with respect to vehicle modifications through the HSW.

**Docket No. 2014-9220 CMH
Decision and Order**

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

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

██████████
Docket No. 2014-9220 CMH
Decision and Order

- 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, July 1, 2013 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, given the information available at the time of the partial denial, Appellant has failed to meet her burden of proof and the CMH's decision must be affirmed. Appellant and her representative both testified that she needs to use a mini-van rather than a full-sized van and that they identified such a need when making the request at issue. However, their testimony is not supported in the record or the documentation submitted to the CMH and ██████████ prior to the partial denial. Instead, the OT evaluation only provides that Appellant requires a van lift and accommodations for van accessibility. The OT evaluation never even uses the word "mini-van" and, while it is possible that the occupational therapist was using "van" and "mini-van" interchangeably, that mere possibility is not enough to satisfy Appellant's burden of proof given the lack of any specific findings regarding the need for a mini-van.

Appellant's representative does point to a letter from Appellant's doctor dated ██████████ and indicating that it is medically necessary for Appellant to use an adapted mini-van rather than full-size van. However, that letter was obtained after the CMH's decision was made in this case and is therefore immaterial to this action. The mere fact that the letter was admitted into evidence does not change this Administrative Law Judge's jurisdiction, which is limited to reviewing the CMH's decision in light of the information it had at the time it made that decision.

To the extent Appellant and her representative have new evidence regarding the alleged medical necessity for a mini-van, they may re-request the mini-van accommodations. The CMH and ██████████ would then have a full opportunity to address

**Docket No. 2014-9220 CMH
Decision and Order**

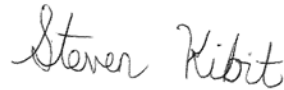
and respond to that new evidence, including an opportunity to seek further clarification from Appellant's doctor. If the request is denied again, Appellant would also have the right to file another appeal. With respect to this appeal, however, the CMH's decision must be sustained given the information available at the time of that decision.

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 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.