STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF

[redacted]

Docket No. 15-015694 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. Attorney [redacted] appeared on Appellant's behalf. [redacted], mother and partial guardian, appeared as a witness for Appellant.

[redacted], Fair Hearing Officer, represented [redacted] (CMH). [redacted], Program Administrator, appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for reimbursement for vehicle modifications?

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] (CMH) under the Habilitation and Supports (HAB) Waiver. (Exhibit G, p 1; Testimony)

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

3. Appellant is diagnosed with cerebral palsy, congenital quadriplegia, focal dystonia, short gut syndrome, neuromuscular scoliosis and supraventricular tachycardia and electrolyte and fluid disorder. (Exhibit G, p 1; Testimony)

4. Appellant is severely physically disabled and unable to care for himself. He has complex care needs due to his medical fragility. He requires the assistance of others to support him with all personal care. His nursing services include: wound care, oxygen administration, administration of IV fluids, central line care, colostomy care and monitoring of fluid output to determine the need for IV fluids. Appellant is non-ambulatory and non-verbal. Appellant is unable to manually operate a wheelchair and uses a power wheel chair in the home and community. (Exhibit G, p 2; Testimony)

5. Appellant lives with his mother and step-father in a single family ranch home. The home includes a wood wheel chair ramp on the front of the home and environmental modifications in the bedroom and bathroom for Appellant's use and benefit. (Exhibit G, p 1; Testimony).

6. Appellant's mother first requested modifications to a new van the family purchased beginning on or about [redacted]. (Exhibit D, pp 8-9; Testimony)

7. Following an Occupational Therapy (OT) Evaluation completed by the CMH on [redacted], it was recommended that Appellant obtain a new van with a taller door to supply him ample head space to accommodate his recent 2.5 inch growth spurt. The OT Evaluation also indicated, "CSTS must explore and determine the most cost effective measures for van modification request." (Exhibit G, p 5; Testimony)

8. Appellant obtained two estimates for van modifications and submitted them to CMH with a request to have the modifications approved. Appellant also included a list of Community Resources that had been contacted regarding assistance with the van modifications in late [redacted]. (Exhibit D, pp 8-10; Testimony)

9. On [redacted], CMH sent Appellant an Adequate Action Notice informing him that the requested van modifications were denied. Specifically, the notice indicated, "Your request for modifications to a van are being denied at this time. It has been determined that there currently exists another appropriate, efficacious, less-restrictive and cost-effective support (a van with modifications that is in good working order) available to [redacted] that does not indicate that a new van with modifications is medically necessary." (Exhibit 3, pp 1-2; Testimony)

10. On [redacted], CMH sent Appellant an Advance Action Notice indicating that there would be a delay in the approval of the requested van modifications. Specifically, the notice indicated:

> Delay in service decision around van modifications will be occurring at this time until the following information is obtained:
>
> 1 – An assessment of the current functioning of the lift on the old van to see if this can be used on the new van. Assessment to be completed by Jourden's.
>
> 2 – Documentation of what coverage private insurance (BCBS) is able to cover on any van modification.
>
> 3 – Community resources for van modifications are approached for assistance, along with documentation.
>
> This information is needed as a way to determine if there is another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services.
>
> (Exhibit 3, pp 3-4; Testimony)

11. In order to comply with item 2 from the [redacted] Notice, Appellant was required by his private insurance company, BCBS, to partially pay for the van modifications, by ordering the parts through the vendor, and submit the receipt for that payment to the insurance company. Appellant began this process by ordering the parts for the van modification in [redacted]. (Exhibit D, p 6; Testimony)

12. On [redacted], CMH sent Appellant an Adequate Action Notice informing him that the requested van modifications were denied. Specifically, the notice indicated:

> Your request for modifications to a van are being denied at this time. Previous request was delayed due to needing the following information, which has still not be (sic) obtained:
>
> [The notice then listed items 1 and 2 from the [redacted] Notice, but not item 3]
>
> (Exhibit 3, pp 5-6; Testimony)

13. In [redacted], the parts for the van modification Appellant previously ordered in [redacted] arrived and the van modification was completed at a total cost of $10,246.00. (Exhibit 4, pp 1-2, Exhibit D; Testimony)

14. On [redacted] Appellant, through his attorney, submitted a request for reimbursement of the van modifications. The request included the denial from BCBS, a copy of the community resources previously provided to CMH in [redacted], and information on how the ramp on the previous van could be assessed. (Exhibit D, Testimony)

15. On [redacted], CMH sent Appellant an Adequate Action Notice informing him that the request for van modifications was denied. Specifically, the notice indicated, "Your request for modifications to a van are being denied at this time. The reason that this request is being denied is due to the fact that the modifications have already been installed in the vehicle without prior approval. This is not the process that we use for modifications." (Exhibit A, pp 1-2; Testimony)

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

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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services 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 Medicaid Provider Policy Manual (MPM) outlines Medicaid policy in Michigan. It provides in relevant part:

> **SECTION 2 – PROGRAM REQUIREMENTS**
>
> ****
>
> **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;
    - that are 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.

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.

HSW beneficiaries must be enrolled through the MDHHS 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/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID 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 MDHHS Bureau of Community Based 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.

15.1WAIVER SUPPORTS AND SERVICES

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.

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.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
July 1, 2015, pp 13, 96, 98-99
Emphasis added

CMH's Program Administrator testified that he has worked at CMH for 10 years and has been a supervisor for 3 years. CMH's Program Administrator explained that Appellant's request for vehicle modifications was denied on [redacted] because Appellant was asking for reimbursement for something that had already been completed without first obtaining prior authorization. CMH's Program Administrator testified that under the HAB Waiver and CMH's policies, there are certain steps that must be taken prior to the approval of any vehicle modification and that those steps were not followed here by Appellant. CMH's Program Administrator also indicated that because Appellant is not a Medicaid provider, CMH could not reimburse him for the vehicle modifications that had already been completed.

On cross-examination, CMH's Program Administrator indicated that Appellant is receiving Case Management services, which could have included some help in getting the van modifications approved. CMH's Program Administrator indicated that CMH informed Appellant back in [redacted] that there were three pieces of information CMH needed before they could approve the vehicle modifications. CMH's Program Administrator testified that she was informed that Appellant's old van had a lift on it, but that she never personally saw the lift. When shown through Appellant's OT Evaluation that the old van actually had a ramp and not a lift, CMH's Program Administrator indicated that by lift she simply meant whatever mechanism Appellant used to get into the van. CMH's Program Administrator testified that she did not know what the process would be for Appellant to get a denial from BCBS, his private insurance, for the vehicle modifications. CMH's Program Administrator testified that she was aware that Appellant had provided a list of community resources for the modifications back in [redacted], but she felt there might be some resources available at some of the locations in [redacted].

When asked to point to policy in the MPM which indicates that Appellant cannot be reimbursed for the van modifications because he is not a Medicaid provider, CMH's Program Administrator pointed to the policy highlighted above. CMH's Program Administrator reasoned that since that policy speaks to making payments to medical suppliers, CMH cannot make payments to Medicaid beneficiaries. When asked to point to the legal authority for the action taken in the [redacted] Adequate Action Notice, CMH's Program Administrator pointed to 42 CFR 440.230, but acknowledged that the Notice did not make reference to policy in the MPM cited above. CMH's Program Administrator did indicate, however, that the actual reason for the denial, and the authority for that denial, was relayed to Appellant verbally prior to the Notice being mailed out.

Appellant's mother and partial guardian testified that BCBS, the family's private insurance, does not preauthorize services. Appellant's mother and partial guardian indicated that the only way to obtain a denial from BCBS is to actually pay for the services first and then submit a receipt for the services to BCBS. Appellant's mother and partial guardian testified that this is exactly what they did with the van modifications – they paid, in part, for the modifications, then submitted the receipt to BCBS, and obtained the denial found in Exhibit D, pp 5-7. Appellant's mother and partial guardian testified that the van modifications were completed towards the end of [redacted] or beginning of [redacted].

Appellant first argues that he should be reimbursed for the van modifications because the [redacted] Adequate Action Notice lacks the specificity required by law and policy. While it is true that the Notice is deficient in that it does not provide a specific reference to that portion of the MPM relied on by CMH, the remedy for that deficiency would be an order instructing the CMH to provide proper Notice, not an award of the Medicaid benefits Appellant seeks. Given that Appellant is now aware of the policy relied upon by the Department, and was made aware of that policy at least one week prior to the hearing through the Hearing Summary filed by CMH, there would be no point in ordering the CMH to resend the Notice with the proper references to the MPM at this time. Such an order would simply delay this matter further; a result neither party would want. In the future, CMH should include the proper references to both the law and policy relied upon in its decision.

Appellant next argues that he should be reimbursed for the van modifications because CMH's conduct in denying the modifications was arbitrary and capricious. As Appellant correctly points out, arbitrary is something "without adequate determining principle . . . Fixed or arrived at through an exercise of will or by caprice, without consideration or adjustment with reference to principles, circumstances, or significance, . . . decisive but unreasoned," while capricious is something "apt to change suddenly; freakish; whimsical; humorsome." *See Bundo v City of Walled Lake*, 395 Mich 679 at 703, n.17 (1976).

Here, CMH's actions were not arbitrary and capricious. Policy provides that CMH must "Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services . . ." Policy also provides that [t]here must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. And, policy indicates that, "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." In the present case, CMH informed Appellant that three criteria needed to be met to comply with the above policy and get prior authorization for the van modifications. Nothing about CMH's actions in this regard were apt to change suddenly, freakish, whimsical or unreasoned. Those criteria were:

> 1 – An assessment of the current functioning of the lift on the old van to see if this can be used on the new van. Assessment to be completed by Jourden's.
>
> 2 – Documentation of what coverage private insurance (BCBS) is able to cover on any van modification.
>
> 3 – Community resources for van modifications are approached for assistance, along with documentation.

In late [redacted] or early [redacted], while CMH was still waiting for the above information from Appellant, Appellant had the van modifications completed without prior authorization. Appellant first argued that he did not make the prior van available for

assessment because the notice from CMH indicated that the old van had a "lift", while the van actually had a "ramp". However, the fact that the notice said "lift" instead of "ramp" did not free Appellant from his obligations to comply with Medicaid policy. If Appellant had actually made the van available for assessment in a timely manner, before getting the new van modified, this discrepancy would have been plainly obvious. And while Appellant eventually, through his attorney, made the van available for assessment this did not occur until the modifications to the new van had already been completed.

Appellant did comply with criteria 2 above by obtaining a denial for the modifications from his private insurance, but that information was not provided to CMH prior to the modifications actually being completed. Appellant argued that he could not obtain the denial without first paying for the modifications and submitting a receipt to BCBS, but again, this fact does not free Appellant from complying with prior authorization requirements. There was also no evidence that Appellant informed CMH of this fact before getting the van modifications completed. It appears that Appellant simply proceeded with the modifications confident that he would ultimately be reimbursed for the modifications.

Finally, Appellant did provide a list of community resources researched in order to seek other funding, but the list was from [redacted] and CMH reasonably believed that Appellant should re-contact those agencies because further funding might be available in [redacted].

Based on the evidence presented, Appellant has failed to prove by a preponderance of the evidence, that CMH's denial of reimbursement for van modifications was improper. CMH was required by policy to ensure that the modifications to Appellant's van were the most cost effective alternative and that Medicaid was the payor of last resort. CMH is allowed to require prior authorization for services and equipment. Because Appellant completed the van modifications before the prior authorization process could be completed, CMH was unable to approve the modifications per policy.

It should be noted that CMH also indicated that it could not reimburse Appellant for the van modifications because he was not a Medicaid provider and they can only pay Medicaid providers for service. While this Administrative Law Judge is not convinced that this argument is necessarily true, the issue is ultimately irrelevant here. CMH cannot reimburse Appellant for the van modifications because he failed to obtain prior authorization for those modifications before they were completed.

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 van modifications.

IT IS THEREFORE ORDERED that:

- The CMH's decision to deny Appellant's request for van modifications is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]
Date Mailed: [redacted]

cc: [redacted]

RJM/cg

***** 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.