[redacted]
MI [redacted]

Date Mailed: October 15, 2021
MOAHR Docket No.: 21-004139
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on October 14, 2021. [redacted] and [redacted] Petitioner's parents and guardians, appeared and testified on Petitioner's behalf.

Jackie Bradley, Fair Hearing Officer, appeared on behalf of Respondent, Lenawee Community Mental Health Authority (CMH). Holly Owen, Chief Operating Officer and Interim Program Director; and Kathryn Szewczek, Executive Director, appeared as witnesses for Respondent.

EXHIBITS

Exhibit 1: Request for Hearing, pp 1-2.

Exhibit A: Hearing Summary, pp 1-30.

ISSUE

Did the CMH properly deny Petitioner's request for a wheelchair 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. Petitioner is a [redacted]-year-old Medicaid beneficiary, born [redacted] receiving services through CMH under the Habilitation Supports Waiver (HSW). (Exhibit A, p 12; Testimony)

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

3. On December 11, 2020, Petitioner's doctor submitted a General Supply Request for a wheelchair van lift. Petitioner's case manager worked with Petitioner's parents to identify a provider (Mobility Works) and obtain a quote for the wheelchair van lift. (Exhibit A, p 3; Testimony)

4. On May 13, 2021, CMH sent Petitioner a Notice of Adverse Benefit Determination denying Petitioner's request. The Notice indicated, in part, "Under section 15-1 – Enhanced Medical Equipment and Supplies coverage includes adaptations to vehicles and does not include purchase of a vehicle." (Exhibit A, pp 4-7; Testimony)

5. On May 31, 2021, Petitioner's parents requested an internal appeal. In the appeal, Petitioner's parents explained that they understood the cost of the vehicle would be their responsibility, but they were asking the CMH to pay for the van's modification and installation of a wheelchair van lift. (Exhibit A, pp 8-9; Testimony)

6. On June 25, 2021, Mobility Works provided an estimate that broke out the cost of the van from the cost of the modifications and wheelchair van lift. The estimate for the cost of the modifications and wheelchair van lift was $25,347.00. (Exhibit A, p 21; Testimony)

7. On June 25, 2021, CMH sent Petitioner's parents a Notice of Delay, explaining that the internal appeal would not be concluded within the statutory guidelines. (Exhibit A, pp 13-14; Testimony)

8. On July 9, 2021, CMH sent Petitioner's parents a Notice of Resolution of Internal Appeal, which upheld the denial of the wheelchair van lift. The Notice indicated, in part, "This proposal quoted the conversion cost at $25,347. This quote is approximately 2.5 times higher than a similar proposal received from Mobility Works on behalf of another consumer." (Exhibit A, pp 15-16; Testimony)

9. The Mobility Works proposal from another consumer that CMH based its decision on was dated November 17, 2020 but was for a Turny EVO Plus Turning Automotive Seating System, not a vehicle conversion and wheelchair van lift like Petitioner requested. (Exhibit A, pp 22-23; Testimony)

10. On August 10, 2021, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (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 Health and Human Services (MDCH) 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 CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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.

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
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2021, pp 12-14
Emphasis added

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 covered state plan 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 PIHP's 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 habilitative 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.

15.1 WAIVER 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 (e.g., outdoor play equipment, swimming pools, pool decks and hot tubs). **(text added 4/1/21)** 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 Individualized 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*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *July 1, 2021, pp 108; 110-111*
> *Emphasis added*

CMH's COO and Interim Program Director testified that she has been with the agency for 15 years and is a LMSW. CMH's COO indicated that she directly supervises Petitioner's case manager. CMH's COO testified that in Petitioner's case, she reviewed and denied the original proposal from Mobility Works because that proposal included the cost of a new van, which is not a covered service under the HSW. In making that determination, CMH's COO testified that she reviewed Petitioner's records, the proposal, and policy found in the MPM.

CMH's Executive Director testified that she is also a LMSW and has been with the agency for 26 years. CMH's Executive Director indicated that she supervises the clinician who completed the internal appeal. CMH's Executive Director testified that in completing the internal appeal, she and the clinician reviewed Petitioner's records, the proposal, and policy found in the MPM. CMH's Executive Director testified that the denial was upheld because when CMH compared the quote for the wheelchair van lift with a prior proposal for another consumer for similar equipment, the proposal for Petitioner was 2.5 times higher. CMH's Executive Director testified that CMH tried to contact Mobility Works to discuss the matter but were unable to speak to anyone.

Petitioner's parents testified that they specifically enrolled Petitioner in the HSW through CMH to get a wheelchair van lift covered through Medicaid. Petitioner's parents indicated that they understood this to be a covered service through the HSW and their case manager referred them to Mobility Works to get a proposal. Petitioner's parents testified that they knew nothing about Mobility Works prior to the referral and the CMH has never really told them why the request was denied. Petitioner's parents testified that they always understood that they were responsible for the purchase of the vehicle so they could not understand why this was the basis for the first denial. Petitioner's parents also testified that they have no idea why their proposal is higher than that from another consumer, but they went to the only place CMH referred them to and CMH did not offer any other referrals to different companies. Petitioner's parents testified that it is their understanding that this is a complicated process whereby the van first must be converted to fit the lift, and then Mobility Works installs the lift in the van. Petitioner's parents testified that no-one from CMH ever reached out to them and, if they had, Petitioner's parents could have assisted CMH with getting in touch with Mobility Works. Petitioner's parents also indicated that the van from the original proposal has now been sold and they now have a new proposal for another van. Petitioner's parents indicated that the proposal for the conversion of the new van is much lower than the first proposal too, about $18,000.00.

CMH's witnesses confirmed that they have received the new proposal and have been in touch with Mobility Works more recently.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH's denial was improper. Based on the evidence presented, Petitioner has proven by a preponderance of the evidence that CMH improperly denied her request for a wheelchair van lift.

While CMH certainly is required to ensure that Petitioner's request is the most cost-effective van lift possible, CMH's method of determining the reasonableness of the first proposal was improper. Petitioner requested and obtained a proposal for a van conversion and wheelchair lift. The proposal CMH relied upon when determining that Petitioner's proposal was unreasonable was for an entirely different product, as indicated above. CMH never suggested that this other product was medically suitable for Petitioner so it cannot rely on that estimate to determine that Petitioner's first proposal was unreasonable. It should also be noted that CMH's first denial was also improper. CMH first denied Petitioner's request because the proposal included the cost of a van, which is not a covered service under Medicaid. However, Petitioner's parents made it clear that they always understood that the cost of the van was going to be their responsibility.

Therefore, based on the evidence presented, Petitioner has proven by a preponderance of the evidence that the CMH's denial was improper. CMH must work with Petitioner to find a wheelchair van lift that is cost-effective and meets Petitioner's needs. As noted, CMH is already considering a new proposal from Mobility Works with a lower cost for the van conversion and wheelchair lift, so hopefully that process will result in Petitioner receiving this medically necessary equipment.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH improperly denied Petitioner's request for a wheelchair van lift.

IT IS THEREFORE ORDERED that:

The CMH decision is REVERSED.

Within 10 days of the issuance of this Decision and Order, CMH must certify that it is continuing the process of finding a cost-effective wheelchair van lift for Petitioner.

RM/sb

Robert J. Meade
Administrative Law Judge

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS-Location Contact

Kathryn Szewczuk
Lenawee County CMHSP
1040 South Winter St
Adrian, MI
49221-3867
KSzewczuk@LCMHA.org

DHHS -Dept Contact

Belinda Hawks
Lewis Cass Building
320 S Walnut St
Lansing, MI
48913
MDHHS-BHDDA-Hearings@michigan.gov

Authorized Hearing Rep.

[redacted]

Petitioner

[redacted]
MI

DHHS Department Rep.

Jaclyn Bradley
1040 S. Winter St Ste 1022
Adrian, MI
49221
jbradley@LCMHA.org