STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 17, 2017
[redacted]
AGENCY: MAP
FH #: 7535800P

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on July 17, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Long Term Care Plan (Centers Plan for Healthy Living)

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the Managed Long Term Care Plan's determination to deny Appellant's request for two monaural hearing aids correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 57, has been in receipt of Medical Assistance through a Managed Long Term Care Plan (MLTC), Centers Plan for Healthy Living (hereinafter, the Plan).

2. The Appellant suffers from complete hearing loss in his right ear, partial hearing loss in his left ear and blindness in both of his eyes.

3. The Appellant requested approval for two monaural hearing aids for his left ear.

4. By written notice, Initial Adverse Determination dated April 25, 2017, the Plan approved the Appellant for one monaural hearing aid because the Medicaid guidelines allow for one hearing aid per ear per every five years.

5. On May 17, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

> 2. "Medical Assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized by this title or the regulations..., which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations...

Section 364.2 of the Social Services Law provides in part, as follows:

> The Department of Health shall be responsible for . . .
>
> (b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. Pursuant to 18 NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

> a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH

shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

b) [Applicable to the HIV SNP Program Only]: The Contractor must promote access and ensure referrals to fee-for-service Medicaid benefits through the HIV SNP care and benefit coordination process for Enrollees determined to be in need of such services.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and shall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

A detailed list of the scope of benefits provided in the Medicaid Managed Care Prepaid Benefits Package is listed in Appendix K of the Medicaid Managed Care/Family Health Plus Contract ("Model Contract").

Appendix J, Section B2 of the Model Contract, entitled, "Identification of Enrollees with Disabilities Standard for Compliance", requires Managed Care Plans to implement "satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services etc." Section E requires Managed Care Plans to have methods for identifying persons at risk of, or having, chronic disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc.

18 NYCRR 505.31 provides that the Medicaid program includes coverage of hearing aid services (which includes the selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing, and hearing aid repairs) and hearing aid products (hearing aids, earmolds, batteries, special fittings and replacement parts). A prescription for a specific hearing aid requires a pure tone and sound field speech audiometry. The tests must be conducted by or under the direction and personal supervision of an otolaryngologist or qualified audiologist. When a specific device is prescribed, the hearing aid dealer must dispense as written. When a general

recommendation is made, the hearing aid dealer must perform tests and procedures necessary to determine the specific hearing aid which will be of maximum benefit to aid or improve the impaired hearing. Prior approval from the New York State Department of Health is required for hearing aids, dispensing and administrative fees as defined by regulations of the New York State Department of Health, and special fittings when the source of the recommendation is not a speech and hearing center approved to provide services under the Physically Handicapped Children's Program. Batteries not listed in the department's provider manual and repairs costing $70 or more require prior approval from the New York State Department of Health regardless of the source of the order.

The New York State Medicaid Hearing Aid/Audiology Services Policy Guidelines set forth the following coverage criteria for hearing aids:

Medicaid reimbursement for hearing aids is dependent upon documented medical need and a statement (psycho/social assessment) that the patient is alert, oriented and able to utilize their aid appropriately and the following criteria, **regardless of order source**:

Monaural Hearing Aid

• Hearing loss in the better ear of 30 dBHL or greater (re - ANSI 1969) for the pure tone average of 500, 1000 and 2000Hz.

• A spondee threshold in the better ear of 30 dBHL or greater when pure tone thresholds cannot be established.

• Hearing loss in each ear is less than 30 dBHL at the frequencies below 2,000 Hz and thresholds in each ear are greater than 40 dBHL at 2,000 Hz and higher

Binaural Hearing Aid

Same as the criteria for Monaural Hearing Aid plus **<u>one or more</u>** of the following:
• significant vocational or educational demands;
• previous user of binaural hearing aids within the past five (5) years supported by written documentation of medical need;
• significant visual impairment, i.e. severe low vision as defined by the AMA best corrected visual of 20/200 or below or a visual acuity score of < 50; and
• children.

Section 358-5.9(a) of the Regulations provides in part that at a fair hearing concerning the denial of an application for or the adequacy of medical assistance or services, the appellant must establish that the agency's denial of assistance was not correct or that the appellant is eligible for a greater amount of assistance.

DISCUSSION

The Appellant requested this fair hearing to contest the Plan's determination of April 25, 2017 to approve one monaural hearing aid for his left ear and not provide and not provide the Appellant with an approval for two monaural hearing aids for the left ear. Per the Plan's April 25, 2017, the Plan did not provide two monaural hearing aids because the Medicaid guidelines only allow for one hearing aid per ear per every five years.

At the hearing, the Appellant testified that he suffers from complete hearing loss in his right ear, partial hearing loss in his left ear and blindness in both of his eyes. The Appellant testified that he needs a second monaural hearing aid for his left ear as a back-up hearing aid. The Appellant explained that every three months, his monaural hearing aid requires maintenance which would temporarily render him without a hearing aid until the maintenance is complete. The Appellant also testified that if the monaural hearing aid malfunctions, then he will need a back-up or second monaural hearing aid for the left ear. The Appellant explained that it is imperative that he has a back-up monaural hearing aid due to the complete hearing loss in his right ear and blindness in both eyes. The Appellant stated that he cannot survive without the ability to hear in at least one ear. The Appellant also testified that he receives personal care services in the amount of ten hours per day for seven days per week (9 a.m. thru 7 p.m. for seven days per week). The Appellant stated that he is in the home alone from 7 p.m. until 9 a.m.

The Appellant presented into the record a letter from his primary physician, dated February 16, 2017, which states the following:

> "…[the Appellant] has several serous and chronic conditions including blindness, haring loss and other limitations that make him currently unable to work. [The Appellant] requires daily assistance by a home care attendant for his activities of daily living. He is disabled."

Notably, the New York State Medicaid Hearing Aid/Audiology Services Policy Guidelines does not limit the amount of hearing aids per ear. Nevertheless, the Appellant did not present medical documentation to support his contention that he requires a second or "back-up" monaural hearing aid for his left ear. Thus, the Plan's determination to deny Appellant's request for two monaural hearing aids must be sustained.

DECISION AND ORDER

The Managed Long Term Care Plan's determination to deny Appellant's request for two monaural hearing aids was correct and is affirmed.

FH# 7535800P

DATED: Albany, New York
08/04/2017

NEW YORK STATE DEPARTMENT OF HEALTH

By

Commissioner's Designee