STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: May 2, 2017
[redacted]
AGENCY: MAP
FH #: 7526154Q

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

Did the Appellant provide a good cause reason for failing to appear at a fair hearing on June 1, 2017, which had been scheduled to review the April 25, 2017 determination by the Managed Long Term Care Plan, which denied a request for a prior approval authorization regarding a power wheelchair for the Appellant?

In the event that the Appellant has established a good cause reason, was the April 25, 2017 determination by the Managed Long Term Care Plan to deny the Appellant's request for a prior approval authorization for a power wheelchair 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 63, has been in receipt of Medical Assistance, provided through the Managed Long Term Care Plan, Centers Plan for the Healthy Living (hereinafter, the Plan).

2. On behalf of the Appellant, a request was submitted to the Plan for a prior approval authorization for a power wheelchair for the Appellant.

3. By Notice of Intent dated March 7, 2017, the Plan informed the Appellant of its determination to deny the request for a power wheelchair for the Appellant.

4. The Appellant originally requested a fair hearing on May 2, 2017 to review the Plan's determination dated March 7, 2017.

5. Based on the original fair hearing request of May 2, 2017, a fair hearing was scheduled for June 1, 2017, to review the Plan's determination but he did not appear, either personally or by representative.

6. Upon the Appellant's failure to appear at the scheduled fair hearing, either in person or by representative, the Office of Administrative Hearings issued a letter dated June 3, 2017 to the Appellant's address of record, asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing.

7. The Office of Administrative Hearings received a response from the Appellant requesting that the hearing be rescheduled.

8. This present fair hearing was scheduled in response to Appellant's request for rescheduling.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

Regulations at 18 NYCRR 358-5.5 provide that the Office of Administrative Hearings of the New York State Office of Temporary and Disability Assistance (OAH) will consider a fair hearing request abandoned if neither the Appellant nor the Appellant's authorized representative appears at the fair hearing, unless either the Appellant or Appellant's authorized representative has contacted OAH to request that the fair hearing be rescheduled and has provided OAH with a good cause reason for failing to appear at the fair hearing on the scheduled date. OAH will restore a fair hearing to the calendar if the above requirements have been met. In no event will a defaulted fair hearing be restored to the calendar if the request to do so is made one year or more from the date of the defaulted fair hearing.

Pursuant to the terms of stipulation in the federal class action entitled Fishman v. Daines v (EDNY, 09CV5248, Bianco, J., April 6, 2011), if an applicant for or recipient of Medical Assistance requests a fair hearing to contest the adequacy, denial, reduction, restriction or termination of Medicaid benefits and fails to appear, either in person or by representative, at a fair hearing defaulted on or after February 26, 2011, the Office of Administrative Hearings will issue a "default letter" to the applicant or recipient's address of record asking if the fair hearing request has been abandoned. This letter advises the applicant or recipient that if he or she is requesting a rescheduled hearing date, he or she must provide a good cause reason for defaulting the hearing. The default letter also advises the applicant or recipient that if the Office of Administrative Hearings does not receive a response to such letter postmarked within ten days of the mailing date, the hearing request will be deemed abandoned.

The stipulation further provides that, if the Office of Administrative Hearings receives a response from the applicant or recipient within ten days of the mailing date of the default letter and postmarked within ten days of the mailing date of such letter, requesting a rescheduled hearing date, the hearing will be rescheduled. At the rescheduled hearing, the good cause explanation for the failure to appear on the original hearing date will be addressed by the administrative law judge and, if necessary, the merits of the subject hearing request will thereafter be addressed by the administrative law judge. OAH Transmittal Number 13-01 advises that the court order regarding Fishman v. Daines (EDNY, 09CV5248, Bianco, J., April 6, 2011) was vacated and the procedures outlined above will no longer be applicable.

OAH Transmittal Number 16-001 advises that pursuant to a preliminary injunction in Fishman v. Daines (09-cv-5248 EDNY, issued by the US District Court on March 4, 2016) requiring the Office of Administrative Hearings to issue a letter (Fishman Default Letter 18) to the appellant and the appellant's representative upon default of a fair hearing requested to contest the adequacy, denial, discontinuance, restriction or reduction of Medicaid benefits (MA- only hearings). The letter instructs clients who wish to have their hearing rescheduled to respond to the letter within 10 days of the date of the post mark. Note that the date of the letter will be the mailing date, approximately two business days after the scheduled date of the hearing. If no response is received by OAH, then the appellant will be defaulted and the case dismissed. When a response is received, the case will be rescheduled and the Hearing Officer will make a determination if the appellant had good cause for missing the initially scheduled hearing date. If the appellant had aid-to-continue, the benefits remain in place until the decision is issued. Additionally, if the appellant requests a re-opening of their Medicaid-only fair hearing after a default has been entered, the Office of Administrative Hearings will apply regulation 18 NYCRR 358-5.5, which is used for defaults in other types of hearings (e.g. Public Assistance and SNAP).

Section 358-5.9 of the Regulations provides in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is

eligible for a greater amount of assistance or benefits.

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.

Also, pursuant to that section of Regulations, the purpose of the prior approval process is to assure that: the requested medical, dental and remedial care, services or supplies are medically necessary and appropriate for the individual recipient's medical needs; other adequate and less expensive alternatives have been explored and, where appropriate and cost effective, are approved; and the medical, dental and remedial care, services or supplies to be provided conform to accepted professional standards.

18 NYCR section 513.4 is entitled "Obligations and responsibilities of the ordering practitioner and potential provider", and states in relevant portion:

(c) The ordering practitioner and potential provider are responsible for assuring that, in their best professional judgment, the ordered and requested medical, dental and remedial care, services or supplies will meet the recipient's medical needs; reduce the recipient's physical or mental disability; restore the recipient to his or her best possible functional level; or improve the recipient's capacity for normal activity; and that they are necessary to prevent, diagnose, correct

or cure a condition in light of the recipient's specific circumstances and the recipient's functional capacity to make use of the requested care, services or supplies.

(d) The ordering practitioner and potential provider are responsible for assuring that adequate and less expensive alternatives have been explored and, where appropriate and cost effective, are requested and that the medical, dental and remedial care, services or supplies to be provided conform to accepted professional standards.

(e) The ordering practitioner and potential provider must cooperate with the Department of Health in its evaluation of the request and take such actions as the Department of Health may reasonably request to assure proper and timely evaluation of the request.

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

The Managed Long Term Care MODEL CONTRACT provides, in part, that:

ARTICLE V
OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law…

Section I of the New York State Medicaid Program Information for All Providers General Policy defines prior approval as the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

Section IV of the New York State Medicaid Program Durable Medical Equipment Manual Policy Guidelines and Regulations at 18 NYCRR 505.5(a)(1) defines "Durable Medical Equipment" as:

> devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which have all of the following characteristics:
>
> -Can withstand repeated use for a protracted period of time;
>
> -Are primarily and customarily used for medical purposes;
>
> -Are generally not useful to a person in the absence of an illness or injury; and

-Are usually not fitted, designed or fashioned for a particular individual's use.

Where equipment is intended for use by only one patient, it may be either custom made, or customized.

Section 4.4 of the New York State Medicaid Program Durable Medical Equipment Manual Procedure Codes provides that:

Wheeled mobility equipment is covered if the patient's medical conditions and mobility limitations are such that without the use of the WME, the patient's ability to perform mobility related activities of daily living (MRADL) in the home and community is significantly impaired and the patient is not ambulatory or functionally ambulatory. MRADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan completed in customary locations in the home and community.

The New York State Medicaid Program Durable Medical Equipment, Orthotics, Prosthetics and Supplies Procedure Codes and Coverage Guidelines provide detailed clinical and coverage criteria for both manual, power wheelchairs and power motorized scooters.

Section I of the New York State Medicaid Program Information for All Providers General Policy defines prior approval as the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

A September 4, 1998 memorandum to all 50 States from Sally Richardson, Director of the Health Care Financing Administration of the United States Department of Health and Human Services, informed the States that clarification of durable medical equipment (DME) evaluations was required following a ruling in DeSario v. Thomas, 139 F. 3rd 80 (2d Cir. 1998). DME is a component of home health services, which is a "mandatory" benefit under Medicaid, per federal regulation. State standards for determining the extent of home health service (and thus, DME) coverage must be "reasonable", and "based on such criteria as medical necessity or utilization control."

The memorandum further provides that State limitations on mandatory Medicaid services must not be "arbitrary." In this connection, "a State may develop a list of pre-approved items of ME as an administrative convenience because such a list eliminates the need to administer an extensive application process for each ME request submitted." A State must also provide a reasonable and meaningful method for requesting items that do not appear on the State's pre-approved list.

As to such prior approval process, it is imperative that:

The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health

> services benefits. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a State's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.
>
> The State's process and criteria, as well as the State's list of pre-approved items, are made available to beneficiaries and the public.
>
> Beneficiaries are informed of their right, under 42 C.F.R. Part 431 Subpart E, to a fair hearing to determine whether an adverse decision is contrary to the law cited above.

In the memorandum, Director Richardson explicitly rejects a specific test previously adopted by several courts, including the DeSario v. Thomas court, known as the "Medicaid population as a whole test." This test is a method of determining whether a State's decision to exclude an item or service from Medicaid reimbursement is acceptable even if it results in the denial of an item medically necessary to one individual, so long as the State's Medicaid Program adequately meets the requirements of service to the Medicaid population as a whole. Per Health Director Richardson, "a State may not use a 'Medicaid population as a whole' test.... this test, in the ME context, establishes a standard that virtually no individual item of ME can meet."

The Medicaid provider manual advises regarding power wheelchairs and motorized scooters as follows:

POWERED MOBILITY DEVICES (PMD)

Powered Mobility Devices are covered when:

Criterion 1, 2 and 3, below, are met, and criterion is met for specific devices listed below.

The beneficiary has a mobility limitation that impairs his or her ability to

1. participate in one or more MRADL, and
2. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker, and
3. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

NOTE: A PMD will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

Power Operated Vehicles (POV), 4 wheeled, are covered if all of the basic coverage criteria, 1-3, above, for PMDs have been met and if criteria 4-9, below, are also met:

4. The beneficiary is able to:
(a). □ Safely transfer to and from a POV, and
(b). Operate the tiller steering system, and
(c). Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids.

5. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home, and

6. The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and

7. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided, and

8. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs, and

9. The beneficiary has not expressed an unwillingness to use a POV.

NOTE: Group 2 POVs have added capabilities that must be medically justified; otherwise payment will be based on the allowance for the least costly medically appropriate alternative, the comparable Group 1 POV. If coverage criteria 1-9 are met and if a beneficiary's weight can be accommodated by a POV with a lower weight capacity than the POV that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.
Power Wheelchairs (PWC) are covered if all of the basic coverage criteria (1-3) for PMDs have been met and

- □The beneficiary does not meet coverage criterion 4, 5, or 6 for a POV; and
- □Criterion 10-13 (below) are met:

10. The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and

11. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided, and

12. The beneficiary's home and community environments provide adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and

13. The beneficiary has not expressed an unwillingness to use a power wheelchair.

DISCUSSION

The record in this matter establishes that the Appellant has been in receipt of Medical Assistance, Medicaid, and is enrolled in a Managed Long Term Care Plan with Centers Plan for Healthy Living (hereinafter, the Plan). On behalf of the Appellant, a request was submitted to the Agency for a power wheelchair for the Appellant. The evidence further establishes that by Notice of Intent dated March 7, 2017, the Agency informed the Appellant of its determination to deny the request for a power wheelchair for the Appellant.

Thereafter, the Appellant originally requested a fair hearing on May 2, 2017 to review the Plan's determination dated March 7, 2017. Based on the original fair hearing request of May 2, 2017, a fair hearing was scheduled for June 1, 2017, to review the Agency's determination but he did not appear, either personally or by representative. Upon the Appellant's failure to appear at the scheduled fair hearing, either in person or by representative, the Office of Administrative Hearings issued a letter dated June 3, 2017 to the Appellant's address of record, asking if the fair hearing request had been abandoned and advising that if the Appellant requested that such hearing be reopened, the Appellant would be required to provide a good cause reason for defaulting the hearing. The Appellant contacted the Office of Administrative Hearings and this present fair hearing was in response to Appellant's request for rescheduling.

At the hearing, the Appellant testified that he had no knowledge of the fair hearing scheduled for June 1, 2017 because he did not receive the notice advising him of same. The Appellant further testified that he has ongoing issues with receiving his mail. The Appellant explained that his mail is regularly delivered to his neighbor instead of his apartment. The Appellant's testimony is found credible as it was consistent, detailed and not rebutted by the Agency. As such, the Appellant established a credible claim of non-receipt of the notice advising him of the fair hearing scheduled for June 1, 2017 and it is a good cause reason for his failure to appear at the scheduled fair hearing. Thus, the Commissioner has jurisdiction to review the Plan's determination of March 7, 2017.

With regard to the Plan's March 7, 2017, determination which denies the Appellant's request for the necessary prior approval of authorization for a power wheelchair, the evidence establishes that the Appellant's orthopedist submitted a request for a power wheelchair for Appellant. Review of the request shows that the Appellant's orthopedist informed the Plan that the Appellant underwent left above-the-knee amputation, that the Appellant is morbidly obese and suffers from bilateral upper extremity weakness due to cervical spinal stenosis. The Appellant's orthopedist also reported that the Appellant therefore requires a power wheelchair.

As per the Agency's written Initial Adverse Determination dated March 7, 2017, the Agency denied the aforesaid request because physical therapy evaluations completed on February 24, 2017 and February 27, 2017 do not note an absence of sufficient upper extremity function that would prevent Appellant from operating a manual wheelchair. The Plan noted the

Appellant has been using a manual wheelchair since December 2016. At the hearing the Plan presented copies of physical therapy evaluations, a review of which shows that the Appellant is wheelchair bound, and is able to transfer to/from bed to/from wheelchair as well as able to feed himself without assistance.

At the hearing, the Appellant testified that he underwent surgery in December 2016, which resulted in the amputation of his left leg. The Appellant stated that since his surgery, he has been using a manual wheelchair in his home and in the community, but is no longer able to adequately operate it. The Appellant further stated that his health conditions include obesity and poor upper body strength. The Appellant explained that outside of his home, he is only capable of self-propelling his manual wheelchair for half block upon which he requires a fifteen to twenty-minute rest. The Appellant testified that both of his arms "cramp" as he self-propels and that he also experiences shortness of breath upon exertion. The Appellant stated that a power motorized wheelchair is more adequate for his needs as he has the ability to operate it. The Appellant's home attendant also testified that the Appellant cannot self-propel his manual wheelchair when there is an incline. The Appellant's and his home attendant's testimony are found credible as it was consistent, detailed and supported by documentation.

The record in this matter has been reviewed in its entirety. It is undisputed the Appellant is not ambulatory as Appellant is wheelchair bound. The record establishes the Appellant does not have sufficient upper extremity weakness to self-propel a manual wheelchair in the community during a typical day. As such, the record establishes that Appellant is unable to participate in outdoor locomotion which constitutes as a MRADL. Notably, a Uniform Assessment System – Comprehensive Assessment, which assesses activities of daily living (ADLs), defines locomotion as "how moves between locations on same floor (walking or wheeling).
If in wheelchair, self-sufficiency once in chair". Additionally, the record establishes the Appellant has to ability to perform safe transfers in/out of his wheelchair, and the Appellant has the mental and physical capabilities to safely and independently operate the power wheelchair. There is no evidence in the record rebutting that Appellant's home and community environment does not provide adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided.

For these reasons, the March 7, 2017, determination by the Plan cannot be sustained.

DECISION AND ORDER

The April 25, 2017 determination by the Managed Long Term Care Plan, denying the Appellant's request for a prior approval authorization for a power wheelchair for the Appellant was not correct and is reversed.

1. The Managed Long Term Care Plan is directed to approve the Appellant's request for a prior approval authorization for a power wheelchair for the Appellant.

Should the Plan need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
08/11/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee