STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 4, 2017
[redacted]
AGENCY: MAP
FH #: 7659426M

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 February 27, 2018, 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

Alicia Jacobs, Grievance & Appeals Supervisor

ISSUES

Was the determination of the Appellant's Managed Long Term Care Provider not to approve the Appellant's request for wipes for the Appellant correct?

Was the determination of Appellant's Managed Long Term Care Provider to deny Appellant's request for prescription coverage of A & D Ointment correct?

FACT FINDINGS

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 50, has been in receipt of Medical Assistance coverage for herself.

2. The Appellant has been enrolled in and has received care and services through a

partially capitated Managed Long Term Care Health Plan operated by Centers Plan For Healthy Living.

3. With separate prescriptions, the Appellant's physician requested the Plan's permission for "adult wipes" and for prescription coverage of A & D Ointment for Appellant.

4. By notice dated November 27, 2017, Centers Plan For Healthy Living issued an initial adverse determination as to the A & D Ointment. "….the health care service is not covered by your managed care benefits…."

5. By notice dated January 23, 2018, Centers Plan For Healthy Living issued an initial adverse determination as to the wipes because" this item is not a coverable item."

6. On December 4, 2017, the Appellant initially requested this fair hearing.

APPLICABLE LAW

Social Services Law section 365-a(2) states, in part, that the amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

> 1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.
>
> 2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, 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 of the department.

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.

18 NYCRR 513.1 provides the following definition of medical necessity:

(c) Necessary to prevent, diagnose, correct or cure a condition means that requested medical, dental and remedial care, services or supplies would: 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. Necessity to prevent, diagnose, correct or cure a condition must be determined in light of the recipient's specific circumstances and the recipient's functional capacity to use or make use of the requested care, services or supplies and appropriate alternatives.

Public Health Law Section 4403-f provides in pertinent part as follows concerning eligibility for managed long term care:

1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

****

(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care and acute care if so authorized.

****

7. Program oversight and administration

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or
(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes “medically necessary services”" in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place, for enrollees, that includes a grievance process, an appeal process, and access to the State's fair hearing system...

The eMedNY Durable Medical Equipment manual states as follows at page 13-14:

OSTOMY SUPPLIES **(These codes must be billed for ostomy care only)….**

A4402 **#Lubricant, per ounce** (up to 20)

The eMedNY Durable Medical Equipment manual lists as follows for multiple needs:

A4245 **Alcohol wipes, per box** (up to 5) (100's)

Appendix G of the MLTC model contract lists covered and non-covered services for MLTC partial capitation plans:

:

Services When Provided, Would be Covered by the Capitation[1, 2]	**Non-Covered Services; Excluded From The Capitation; Can Be Billed Fee-For-Service**
Care Management	Inpatient Hospital Services
Nursing Home Care (Residential Health Care Facility)	Outpatient Hospital Services
Home Care a. Nursing b. Home Health Aide c. Physical Therapy (PT) d. Occupational Therapy (OT) e. Speech Pathology (SP) f. Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home.[3]
Adult Day Health Care	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME – including Medical/Surgical Supplies, Enteral and Parenteral Formula,[4] and Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Non-emergent Transportation	Chronic Renal Dialysis
Podiatry	Mental Health Services
Dentistry	Alcohol and Substance Abuse Services
Optometry/Eyeglasses	OPWDD Services
PT, OT, SP or other therapies provided in a setting other than a home. Limited to 20 visits of each therapy type per calendar year, except for children under 21 and the developmentally disabled. MLTC plan may authorize additional visits.	Family Planning Services
Audiology/Hearing Aids	Prescription and Non-Prescription Drugs, Compounded Prescriptions
Respiratory Therapy	All other services listed in the Title XIX State Plan
Nutrition	
Private Duty Nursing	
Consumer Directed Personal Assistance Services	
Services Provided Through Care Management:	
Home Delivered or Congregate Meals	
Social Day Care	
Social and Environmental Supports	

At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

Pursuant to GIS Message 13 MA/015, issued on July 19, 2013, at a fair hearing to review the district's denial of a Medicaid application, the Medicaid applicant has the burden of proving that the district's denial was incorrect. When the applicant prevails, the fair hearing decision will reverse the denial. The district cannot deny the application based on the reason that was set forth in the agency's denial that was reversed. If no remaining eligibility factors need to be considered, the district must find the applicant eligible for Medicaid. When a fair hearing decision reverses the denial of a Medicaid application and one or more remaining eligibility factors need to be considered, the district must continue to process the application and issue a decision as soon as possible. In such cases, the applicant's original application date must be preserved.

Social Services Law Section 365-a.8, as amended, states:

When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP 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.

DISCUSSION

The Appellant, age 50, has been enrolled in and has received care and services through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan For Healthy Living. With separate prescriptions, the Appellant's physician requested the Plan's authorization for "adult wipes" and for prescription coverage of A & D Ointment for Appellant. By notice dated November 27, 2017, Centers Plan For Healthy Living issued an initial adverse determination as to the A & D Ointment. "….the health care service is not covered by your managed care benefits…." By notice dated January 23, 2018, Centers Plan For Healthy Living issued an initial adverse determination as to the wipes because" this item is not a coverable item." The Appellant requested this hearing for review.

The MLTCP's representative stated the request for A & D Ointment was denied as prescription drug coverage is not included as part of the MLTC contract. As the representative correctly stated, drug coverage is directly through Medicaid fee-for service. Nonetheless, it is

noted that durable medical equipment is part of the MLTC provider's obligations. There is indeed one authorized usage for A &D Ointment in the durable medical equipment provider manual—for ostomy patients to prevent chafing around the area of the ostomy bag. The manual makes clear that no other purpose is authorized. However, Appellant wants the ointment to apply to the perineum, inner thighs, and buttocks. As this is not the designated use listed in the provider manual, Centers Plan must be upheld in its denial.

The MLTCP representative also alleged the request for the wipes was for fee-for-service Medicaid to deal with, not for the Managed Long Term Care Plan. However, alcohol wipes are listed under Code A 4245 for multiple uses in the durable medical equipment provider manual. As a DME item, the MLTCP is on the hook to provide it to qualified individuals. Appellant further testified that the MLTCP has approved wipes for her in the past.

Although given proper notification as to the time, place, and subject matter of this hearing, the MLTCP failed to provide crucial documentation from its case record. Its failure to do so is contrary to applicable regulations and makes meaningful review impossible. Specifically, the MLTCP failed to provide information as to whether alcohol wipes, as opposed to other kinds, were intended, and whether any contraindications to receiving alcohol wipes exist. With the grave deficiencies in the case record, Centers Plan can not be upheld in its denial of wipes for Appellant.

DECISION AND ORDER

Centers Plan for Healthy Living's November 27, 2017 determination to not provide the Appellant with A & D Ointment was correct.

Centers Plan for Healthy Living's January 23, 2018 determination to not provide the Appellant with wipes was not correct and is reversed.

1. The MLTC Plan is directed to allow Appellant's physician an opportunity to request alcoholic wipes, code A4245, if those are the ones Appellant requires.

2. If the physician requests such wipes under such code, the MLTC Plan is directed to grant the prior approval authorization in the amount of five (5) units monthly for a reasonable period of time (source, State Medicaid EMedNY DME Fee Schedule).

As required by 18 NYCRR 358-6.4, Centers Plan for Healthy Living must comply immediately with the directives set forth above.

DATED: Albany, New York
03/20/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee