STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 28, 2018
[redacted]
AGENCY: MAP
FH #: 7783010L

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 August 3, 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 (Centers Plan for Healthy Living)

On Papers Only - Appearance Waived by the Office of Administrative Hearings

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for a wheelchair ramp, 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 98, is in receipt of authorization for Medical Assistance and is enrolled in a Medicaid managed long term care plan operated by Centers Plan for Healthy Living ("the Plan").

2. The Appellant has been in receipt of 24 hour Live-in personal care services.

3. The Appellant lives in a private home with five steps at the front door.

4. On January 31, 2018, the Plan completed a Uniform Assessment System – Assessment Report of the Appellant.

5. On or about May 4, 2018, a physician's request was submitted to the Plan for authorization for a wheelchair ramp for the Appellant's home.

6. By notice dated May 11, 2018, the Plan denied the request for the wheelchair ramp on the grounds that it was not medically necessary.

7. The Appellant's representative appealed the May 11, 2018 determination.

8. On June 18, 2018, the Plan completed a Uniform Assessment System – Assessment Report of the Appellant.

9. By Final Adverse Determination dated June 22, 2018, the Plan upheld its initial determination to deny the request for the wheelchair ramp, on the grounds that it was not medically necessary.

10. On June 28, 2018, this fair hearing was requested.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. 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).

Social Services Law §365-a(2) provides that "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 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.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

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...

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

Article 49 of the New York State Public Health Law pertains to Utilization Review and External Appeal.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS, NUMBER: 11-W-00114/2, TITLE: Partnership Plan Medicaid Section 1115 Demonstration, AWARDEE: New York State Department of Health.

Article V (A) of the Managed Long Term Care Contract provides in part:

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42 CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

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. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42 CFR 438.206 for availability of services; and 42 CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appendix G, Managed Long-Term Care Covered/Non-Covered Services states that social and environmental supports are provided through care management.

APPENDIX J
DEFINITIONS

Terms used in this Contract, which are not otherwise defined, shall have the meanings set forth below.

Definitions of covered services are intended to provide general information about the level of care available through the Medical Assistance Program. The full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual. Managed care organizations may not define covered services more restrictively than the Medicaid Program. Contractors are expected to provide services for individual Enrollees as described in each Enrollee's plan of care. Services may be provided either directly or through a sub-contract.
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Medically necessary means necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with an Enrollee's capacity for normal activity, or threaten some significant handicap.
***
Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes that by Final Adverse Determination dated June 22, 2018, the Appellant's Medicaid Managed Long Term Care Plan, Centers Plan for Healthy Living ("the Plan"), upheld its initial May 11, 2018 determination to deny the 98 year-old Appellant's request for a wheelchair ramp, on the grounds that it was not medically necessary.

The May 11, 2018 determination stated, "According to the Uniform Assessment (UAS) performed on 1/31/18, you use a rolling walker (rollator) in your home. The clinical information does not support your needing to use a wheelchair in order to leave your home. The request for construction of a wheelchair ramp, therefore, cannot be authorized (request is denied)." The June 22, 2018 Final Adverse Determination stated, "The denial for a wheelchair ramp is upheld (continues to be denied). The clinical information provided does not support you needing to use a wheelchair in order to leave your home. Our records indicate that you use a rolling walker (rollator) in your home. Medical necessity is not met for a wheelchair ramp."

The Appellant's representatives stated the Appellant lives in a private home with five steps leading to the front door, and a wheelchair ramp is needed to allow the Appellant to enter and leave his home safely. The Appellant's witness credibly stated that the Appellant has not been able to use a rollator for approximately four or five months and is basically wheelchair bound. She stated he has been isolated at home, unable to go outside and socialize, and is becoming increasingly angry and depressed. She stated the personal care assistant is not able to lift him, and he only leaves home once a month for certain medical appointments by ambulette service. Appellant's counsel argued that in the event of an emergency, the Appellant would effectively be trapped and unable to leave his home.

Regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant's representatives have done so.

The testimony of Appellant's representatives was consistent, detailed and persuasive. In addition, the Plan's rationale for denial, as stated in the notices, does not make sense; Appellant's alleged use of a rollator in his home would not in itself "not support needing a wheelchair" in order to leave his home. Nonetheless, this assertion has been rebutted by credible testimony that the Appellant is wheelchair bound. Furthermore, the Plan's own January 2018 and June 2018 assessments do not support the determination, for example, reflecting the Appellant's "Total Dependence" for "Locomotion". Moreover, the Plan's evidence packet contains a letter from [redacted] dated June 6, 2018, describing how they have been providing medical services to the Appellant in his home due to his "multiple comorbidities", including lack of strength of bilateral lower extremities, which make it difficult for him to leave his house. The record reflects improper evaluation of Appellant's needs as related to this request, pursuant to the definition of "medically necessary" as indicated by the Regulations and the Managed Care Long Term Care Partial Capitation contract. Accordingly, the Plan's determination is not sustained.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living, to deny the Appellant's request for a wheelchair ramp was not correct and is reversed.

1. Centers Plan for Healthy Living is directed to approve the Appellant's physician's request for a wheelchair ramp for the Appellant, and notify the Appellant, in writing, of compliance with this Decision.

Should Centers Plan for Healthy Living 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 Centers Plan for Healthy Living promptly to facilitate such compliance.

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
09/05/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee