STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted] **2017**
Signature Confirmation

Client ID #[redacted]
Request #827988

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, Community Health Network of Connecticut ("CHNCT") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying his request for a power wheelchair with hooks and a standing component. The notice stated that the requested equipment was not medically necessary because it was not based on an assessment of his specific medical condition.

On [redacted] 2017, the Appellant requested an administrative hearing to contest CHNCT's decision to deny the power wheelchair with standing component and hooks.

On [redacted] 2017, CHNCT issued a notice to the Appellant advising that his request for a Permobil F3 power wheelchair was approved but the request for the F5 Corpus upgrade (standing component) and medical bag hooks was denied.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2017.

On [redacted] 2017, the Appellant requested a continuance and change of venue for the hearing, which OLCRAH granted.

On [redacted] 2017, OLCRAH issued a notice scheduling an administrative hearing for [redacted] 2017.

On [redacted] 2017, the Appellant withdrew his request regarding the denial of the medical bag hooks.

On [redacted] 2017, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted], the Appellant
[redacted], the Appellant's son
[redacted] the Appellant's physical therapist
[redacted], ATP, representing National Seating & Mobility
[redacted], Direction of Rehabilitation, [redacted] facility
[redacted], Appellant's friend
Robin Goss, RN, BSN, Appeals & Grievances Analyst, CHNCT
Maureen Foley Roy, Hearing Officer

The hearing officer held the hearing record open for the submission of additional evidence. On [redacted] 2017, the hearing record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether CHNCT'S decision to deny the Appellant's request for an F5 Corpus VS Upgrade (power standing system) was correct.

FINDINGS OF FACT

1. The Appellant is a recipient of Medicaid with Community Health Network, Inc. ("CHNCT") as the selected managed care organization. (Hearing Record)

2. On [redacted] 2016, the Appellant's primary care physician approved standing training and stated her willingness to request further testing if the training necessitated such due to the Appellant's bone health or pain. (Exhibit 1: Prior Authorization Request, pg. 27: [redacted] 2017 statement from physical therapist)

3. The Appellant has had success with the standing trials. He has experienced no pain or swelling and there has been no indication that he cannot tolerate standing. During the trials, the Appellant showed the ability to reposition himself. (Exhibit 1: Prior Authorization Request, pg. 27: [redacted] 2017 statement from physical therapist)

4. At the time that the standing trials commenced, the Appellant was 64 years old. His diagnoses include severe cerebral palsy with right sided hemiplegia.

In recent years, he suffered a traumatic brain injury ("TBI"). (Exhibit 1: Prior Authorization Request and Appellant's testimony)

5. The Appellant is under the care of a physiatrist for his spasticity. (Exhibit 23: report from Dr. [redacted])

6. On [redacted] 2017, the Appellant's orthopedic doctor reported that the Appellant was capable of standing and that he could stand antigravity. The orthopedist also stated his belief that the musculosketal health of the Appellant's lower extremities would be "more" if he could bear weight. (Exhibit 1, page 4: Letter from [redacted], Department of orthopaedic surgery)

7. On [redacted] 2017, CHNCT received a prior authorization request for the purchase of customized wheelchair with a standing component for the Appellant. (Exhibit 1)

8. The Appellant will not use the stander component for continuous standing but to go from sitting to standing throughout the day. The Appellant has been working with his physical therapist since October of 2016 to build up his standing hours. (Physical therapist's testimony)

9. There are many benefits to standing; including by not limited to: promoting bone health, improving circulation, reducing abnormal muscle tone and spasticity, reducing the occurrence of pressure ulcers, and reducing the occurrence of skeletal deformities. (Appellant's Exhibit A: RESNA (Rehabilitation Engineering and Assistive Technology Society)position paper)

10. Having a stander would allow the Appellant access to areas in his kitchen and decrease the need for set up with meals.(Exhibit 1: page 14)

11. The Appellant is not incontinent and is able to use a urinal in bed but cannot access a toilet or urinal in his wheelchair. (Exhibit 1: page 11)

12. The Appellant is not a candidate for a Texas catheter or a Foley catheter and currently must urinate into a brief and wait for a caregiver to change the brief. Due to using a brief to urinate, the Appellant gets frequent fungal infections, incontinence associated dermatitis and cracks in the skin resulting in open areas in the groin region. (Exhibit 18: Additional Medical Information submitted by Hudson Home Health, pg 10: Letter from physical therapist dated [redacted] 2016)

13. The physical therapist used a goniometer to obtain the range of motion measurements and reported that the Appellant's has the ability to reposition himself after using the standing component of the power wheelchair. During the trials, the Appellant demonstrated the ability to attain a neutral pelvic and

spinal alignment. (Exhibit 20: and exhibit 1: page 27: letter from physical therapist dated [redacted] 2017 and physical therapist's testimony)

14. CHNCT received the range of motion measurements provided by the Appellant's physical therapist. There is no specific measurement in the law regarding range of motion measurements and ability to use the standing apparatus. (CHNCT's testimony)

15. A bone density test is used to test for osteoporosis. There is no specific measurement with a bone density test correlating to risk of fracture. (Physical therapist's testimony & CHNCT representative's testimony)

16. On [redacted] 2017, CHNCT denied the request for a power wheelchair with standing component stating the request was not based upon an assessment of the Appellant's medical condition. (Exhibit 6: Denial Notice)

17. On [redacted] 2017, CHNCT approved the Appellant's request for a power wheelchair. (Exhibit 26: Care Manager Note Detail dated [redacted] 2017)

18. On [redacted] 2017, CHNCT denied the standing component for the power wheelchair. CHNCT stated that it could not determine if the stander was medically necessary. CHNCT stated it could not determine if the stander was clinically appropriate without a comprehensive evidence based evaluation from an orthopedic physician which would include: lower extremity range of motion measurements, spinal and pelvic positioning evaluation and presence/ absence of deformities or postural deviations, X rays, and results of a bone density test. (Exhibit 26)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes designates the Department of Social Services to be the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

3. Section 7b-262 of the Connecticut General Statutes, states in part, that the Commissioner may make such regulations as are necessary to administer the Medical Assistance Program.

4. Sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies set forth set forth the Department of Social Services requirements for the payment of durable medical equipment ("DME") to providers, for clients who are determined eligible to receive services under

Connecticut Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

5. For the purposes of sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, the following definitions apply:
   "Client" means a person eligible for goods or services under the Medicaid program.
   "Department" means the Department of Social Services or its agent.
   "Durable Medical Equipment" or "DME" means equipment that meets all of the following requirements: (A) can withstand repeated use; (B) is primarily and customarily used to serve a medical purpose; (C) generally is not useful to a person in the absence of an illness or injury; and (D) is nondisposable.
   "Medicaid" means the program operated by the Department of Social Services, pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.
   "Prior authorization" or "PA" means approval for the service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.
   "Provider" means the vendor or supplier of durable medical equipment who is enrolled with the Department as a medical equipment, devices, and supplies supplier.

6. Section 17b-262-675 of the Regulations of Connecticut State Agencies provides that payment for DME and related equipment is available for Medicaid clients who have a medical need for such equipment that meets the Department's definition of DME when the item is prescribed by a licensed practitioner, subject to the conditions and limitations set forth in 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies.

7. Section 17b-262-676(a)(1) of the Regulations of Connecticut State Agencies provides that the department shall pay for the purchase or rental and the repair of DME, except as limited by sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, that conforms to accepted methods of diagnosis and treatment and is medically necessary.

8. Section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies provides that when the item for which Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required by the department. The recipient requesting Medicaid coverage for a prescribed item not on the list shall submit such prior authorization request to the department through an enrolled provider of DME. Such request shall include a signed prescription and shall include documentation showing the recipient's medical need for the prescribed item. If the item for which Medicaid coverage is requested is not on the department's fee schedule, the provider shall also include documentation showing that the item meets the department's

definition of DME and is medically appropriate for the client requesting coverage of such item.

9. Section 17b-259b (a) of the Connecticut General Statutes provides that for the purposes of the administration of the medical assistance programs by the Department, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. [Conn. Gen. Stat. § 17b-259b (a)]

10. CHNCT was incorrect when it required that the Appellant submit a comprehensive evidence based evaluation from an orthopedic physician which would include: lower extremity range of motion measurements, spinal and pelvic positioning evaluation and presence/ absence of deformities or postural deviations, X rays, and results of a bone density test.

11. The Appellant provided CHNCT sufficient information regarding his medical condition for CHNCT to make a determination of medically necessity regarding his request for the F5 stander.

12. The F5 stander is medically necessary for the Appellant as it will assist his ability to toilet, eliminating the need for a brief, which has caused fungal and skin infections. In addition, use of the stander will improve the Appellant’s weight bearing ability and musculosketal health.

13. CHNCT was incorrect when it denied the Appellant’s request for the F5 stander because it could not determine medical necessity.

DISCUSSION

CHNCT stated that it had denied the power stander because there were safety concerns regarding the Appellant's use of the stander. CHNCT's position was that they lacked the information necessary to determine if the stander was clinically appropriate, and therefore, medically necessary, for the Appellant. However, CHNCT was requesting information, such as range of motion measurements, which it already had. CHNCT was requesting a comprehensive evaluation from an orthopedic physician regarding the Appellant's ability to stand. CHNCT had a statement from the orthopedic physician regarding the Appellant's ability to stand. Finally, CHNCT was requesting a bone density test and X-rays, neither of which correlate specifically to the Appellant's ability to stand. Such results would have to have been interpreted by a physician and the Appellant's orthopedist had already provided his opinion that the Appellant could safely stand.

The regulations state that medical necessity must be based upon an assessment of the individual and his or her medical condition. The Appellant has provided considerable medical information from an orthopedist, his primary care physician and his physical therapist, as well as results from his standing training and trials with the stander to show that the stander is medically necessary for him.

DECISION

The Appellant's appeal is **GRANTED**

ORDER

CHNCT will approve the Appellant's medical provider's [redacted] 2017 prior authorization request for the F5 Corpus upgrade stander.

Compliance with this order is due by [redacted] 2017 to the undersigned and shall consist of documentation that the stander has been approved.

Maureen Foley-Roy

Maureen Foley-Roy
Hearing Officer

PC: Robert Zavosky, MD, DSS Medical Director
Fatmata Williams,
Robin Goss, CHNCT Appeals
[redacted], [redacted] Health Care Center

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3730.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.