	The Delaware Code (31 Del. C. §520) provides for judicial review of hearing decisions. In order to have a review of this decision in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections can be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

In re:

DPCI ID # 0000000000

Ms. Smith, Claimant, C/O Ms. Jones

Appearances: Jennifer Gimler-Brady, Esq., Counsel for Delaware Physician's Care, Inc.

I.

Ms. Smith ("Claimant") opposes a decision of Delaware Physician's Care, Inc. ("DPCI"), acting for the Delaware Medical Assistance Program ("DMAP"), to deny her request for an Ultralightweight manual wheelchair.

DPCI contends that the requested service is not medically necessary. Specifically, they maintain that the service requested is duplicative of another service the Claimant has received, a motorized wheelchair.

The Claimant contends that the manual wheelchair is necessary as a back-up for when her motorized wheelchair requires repairs.

II.

DPCI first denied Claimant's request for a manual wheelchair based upon the requested service failing to meet the medical necessity requirements.

The Claimant forwarded her appeal request to DPCI for an internal appeal with the managed care program.

On March 2, 2011, DPCI, through their Appeals Committee, reaffirmed their denial of the Claimant's request for authorization for the manual wheelchair based upon a determination that the requested service did not meet the medical necessity requirements, as it duplicated a service the Claimant already received. (Exhibit 2).

Following DPCI's denial, the Claimant submitted a request for a State Fair Hearing, which was received on March 22, 2011. (Exhibit 3)

On April 5, 2011, DPCI filed a State Fair Hearing Summary. (Exhibit 1).

The Claimant was notified by certified letter dated April 13, 2011, that a fair hearing would be held on May 27, 2011. During a pre-hearing conference, DPCI agreed to accept additional documentation from the Claimant. The Claimant was given a deadline of June 15, 2011, in which to submit all of her additional documentation. Further, DPCI was given a deadline of June 30, 2011 in order to render its decision. It was agreed that if DPCI upheld its denial, the fair hearing would be continued at a later date. Accordingly, a Continuance was granted on May 27, 2011.

On June 30, 2011, DPCI re-affirmed its denial of the manual wheelchair, as not medically necessary for the afore-mentioned reasons. (Exhibit 4) The Claimant was notified by certified letter dated August 17, 2011, that a fair hearing would be held on September 1, 2011 in Carroll's Plaza, Conference Room "E", 1114 S. DuPont Highway, Dover, Delaware. The hearing was conducted on that date, in which the Claimant failed to appear.

This is the decision resulting from that hearing.

III.

Pursuant to authority conferred by 31 *Del. C.* §§ 502 (5), 503 (b), and 505 (3), the Division of Medicaid and Medical Assistance ("DMMA"), Delaware Department of Health and Social Services, operates the DMAP to provide Medicaid benefits under Title XIX of the Social Security Act to certain qualifying individuals. DMMA has contracted with DPCI, a managed care organization, to administer benefits under the DMAP. As an agent for DMMA, DPCI is governed by the same rules, regulations, and principles that would otherwise control DMMA's operation of the DMAP. In fact, this is explicitly required by regulation. *See Division of Social Services Manual ("DSSM")* § 5304.3.

DPCI is a capitated[1] managed care program that directs, on behalf of the Division of Medicaid and Medical Assistance, benefits covered under Title XIX of the Social Security Act. Jordan Suit is a third party beneficiary of a contract between DPCI and the Division of Medicaid and Medical Assistance. She is a 16-year-old female diagnosed with quadriplegic cerebral palsy.

IV.

Jurisdiction for this hearing is pursuant to §5304 and §5304.3 of the Division of Social Services Manual (DSSM). Under §5304:

an opportunity for a hearing will be granted to any applicant who requests a hearing because his/her claim … is denied… and to any recipient who is aggrieved by any action of the Division of

[1] See 42 CFR 434.2. A capitation fee is paid by DMMA to managed care contractors "for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the period covered by the fee."

Social Services… Only issues described in the notice of action sent to the Claimant or issues fairly presented in the Claimant's request for a fair hearing or in the Division's response in its hearing summary may be presented for the hearing officer's review at the hearing.

Section 5304.3 provides jurisdiction for a hearing of an adverse decision of a Managed Care Organization.

V.

At the time of the hearing, Jordan Suit was a 16-year-old female seeking coverage of an Ultralightweight manual wheelchair. The Claimant currently uses a power wheelchair for mobility, but requested the manual wheelchair as a back-up in the event that her power wheelchair requires repair or if her family's van is unable to transport the power wheelchair.

DPCI received a request for authorization for the manual wheelchair from the Claimant.

DPCI issued a denial and later processed the Claimant's request for internal appeal. DPCI reaffirmed their denial of the request on the grounds that the requested service did not meet medical necessity requirements. The Claimant filed a request for a Fair Hearing with the Division of Medicaid and Medical Assistance seeking to overturn the denial of authorization for the service requested.

VI.

DPCI's denial of the Claimant's request is grounded on the failure of the following guidelines, which establish that the requested services do not meet the definition of medical necessity under the DMAP because the manual wheelchair must be:

- The most appropriate care of service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary

Medical necessity is defined by DMMA at Appendix "H" of the Division of Social Services' Provider Specific Policy Manual. It was published at 2:7 Delaware Register 1250 on January 1, 1999.

Specifically, DPCI, in their fair hearing summary, contends that the Claimant already owns a power wheelchair, and that a manual wheelchair would only duplicate the services the Claimant has received.

A determination of medical necessity involves a three-part test. First, the essential need for medical care or services that will provide a medical benefit must be considered. Next, the use of the services must be reasonably determined to effectuate some assistance or restorative value in the mental or physical condition of an appellant. Finally, it must serve those purposes so that a Claimant may attain or retain independence or the capacity for self-care.[2]

[2] See the fair hearing decision In re: Mr Doe., Division of Social Services, February 11, 2000.

As a general foundation to the first portion of the definition, there are nine essential components, *all of which must be met in order to determine that a service is medically necessary*.

1) be directly related to the diagnosed medical condition of the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition) and be provided to the beneficiary only;
2) be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, and environment) of the beneficiary and the beneficiary's family;
3) be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living but will not be solely for the convenience of the beneficiary, the beneficiary's family or the beneficiary's provider;
4) be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
5) be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
6) be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary;
7) be sufficient in amount, scope and duration to reasonably achieve its purpose;
8) be recognized as either the treatment of choice (i.e., the prevailing community or statewide standard) or common medical practice by the practioner's peer group, or the functional equivalent of other care or services that are commonly provided;
9) be rendered in response to a life threatening condition or pain, or to treat an injury, illness or other diagnosed condition, or treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

Next, there are a series of five outcomes, only one of which has to be met to comply with the requirements of the overall definition.

1) diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or
2) prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
3) effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or

4) restore or improve physical or mental functionality, including developmental functioning, loss or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or

5) provide assistance in gaining access to needed medical, social, educational or other services required to diagnose, treat or support a diagnosed condition or the effects of the condition.

Only one of these outcomes must be reasonably determined to result from the requested care or service. This is true because it is impossible or very difficult to absolutely guarantee an expected outcome will actually occur. Operationally, those utilizing the Medicaid medical necessity definition must abide by the "reasonableness" factor when evaluating or adjudicating requests for care or service.

VII.

In order to prevail, the Claimant is required to provide credible evidence that DPCI erred in determining that the requested service was not duplicative of other services provided.

Ms. Gimler-Brady, Esq., counsel for DPCI, testified that the Claimant already owns a working, motorized wheelchair, and that a manual wheelchair would merely duplicate the services provided by the motorized wheelchair. Ms. Gimler-Brady testified that during the May 27, 2011 pre-hearing conference, DPCI agreed to accept additional documentation from the Claimant and review its denial determination. Ms. Gimler-Brady testified that after reviewing the documentation the Claimant submitted by June 15, 2011, DPCI upheld its denial of the request for the manual wheelchair as a duplicative service, and therefore was not medically necessary. (Exhibit 4) Ms. Gimler-Brady testified that DPCI has had no further contact with the Claimant since she submitted the additional documentation.

VIII.

The sole issue, with respect to coverage for the requested service, is whether, under the particular circumstances in this case, the Claimant's request for a manual wheelchair is a medically necessary service as set forth by the DMAP. To establish whether the manual wheelchair is medically necessary it must be determined whether the requested service was

- The most appropriate care of service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary

First, in order for the Claimant to prevail, she must establish that 1) the manual wheelchair she requested met meet DPCI's medical necessity standards or 2) that she has established medical necessity for the proposed service by substantial weight. The records and hearing testimony reflect that she has not established either.

In determining whether a service meets medical necessity requirements, the hearing officer must give more weight to physicians who have examined the Claimant and less weight to physicians

who have not after reviewing the medical evidence as a whole. *Urban v. Meconi*, CA No. 051-10-002 (Del. Super, August 10, 2007). In this case, no medical testimony was provided. In addition, no medical documentation was provided.

A review of the record reveals that the Claimant already has a motorized wheelchair. DPCI's records indicate that this wheelchair had been repaired in the past. (Exhibit 4) No documentation or testimony was elicited to show that the Claimant's motorized wheelchair is defective. As the requested manual wheelchair would merely duplicate services already provided to the Claimant via her motorized wheelchair, the manual wheelchair is not medically necessary pursuant to Appendix "H" of the Division of Social Services' Provider Specific Policy Manual. (published at 2:7 Delaware Register 1250 on January 1, 1999)

In this instance, the Claimant has not established that the requested manual wheelchair meets DPCI's medical necessity standards.

IX.

For these reasons, the June 30, 2011 decision of DPCI to deny authorization for the requested manual wheelchair service for Jordan Suit is AFFIRMED.

Date: September 13, 2011

MICHAEL L. STEINBERG, J.D.
HEARING OFFICER

THE FOREGOING IS THE FINAL DECISION OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

September 13, 2011
POSTED

cc: Jennifer Gimler-Brady, Esq., counsel for DPCI
Ms. Smith for Ms. Jones

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 - Copy of DPCI's State Fair Hearing Summary dated April 5, 2011 consisting of three (3) pages.

EXHIBIT #2 – Copy of DPCI's Appeal Committee Voting Panel denial letter dated March 2, 2011 consisting of three (3) pages.

EXHIBIT #3 – Copy of the Claimant's Fair Hearing Request, date-stamped March 22, 2011, consisting of one (1) page.

EXHIBIT #4 – Copy of DPCI's Medical Director's denial letter dated June 30, 2011, consisting of two (2) pages.

EXHIBIT #5 – Copy of DPCI's Notice of Action—Denial letter dated December 23, 2010, consisting of four (4) pages.