

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 14,349

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Appeal of)

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INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare denying him Medicaid coverage for a thoracic-type motorized power lift. The issue is whether the Department's regulation regarding a reimbursement limitation for "patient lifts" denies him access to a medically necessary service and violates provisions in the federal Medicaid statutes and regulations requiring adequate access to services and that services be sufficient in amount, duration, and scope.

In lieu of an oral hearing the parties agreed to admit the handwritten statement of the petitioner's mother and a packet of documents submitted by the petitioner's various care providers and consultants. Those documents form the basis of the findings, below.

This is a companion case with Fair Hearing No. 14,033, which is also pending before the Board at this time. Although the petitioner in this matter was not directly represented by counsel, the parties in this matter represented that the petitioner (through his mother) had consulted with the attorney in Fair Hearing No. 14,033, that the issues in the two matters were nearly identical, and that the Board could consider the legal arguments made in Fair Hearing No. 14,033 as those of the petitioner in this matter.

FINDINGS OF FACT

The petitioner is a seventeen-year-old young man who resides in his parents' home. Due to severe cerebral palsy the petitioner is confined to a wheelchair and has extensive orthopedic deformities and other medical problems.

Earlier this year the petitioner was evaluated by various professional experts for an in-home lifting device for transferring him in and out of his wheelchair, primarily for bathing and toileting. Although "patient lifts" are a covered item in the regulations under "durable medical equipment" (see *infra*), the Department's regulations and policy limit payment for patient lifts to \$913.75, an amount which, while apparently sufficient to purchase most standard-type lifts, is nowhere near the cost of the particular lift that has been recommended for the petitioner.

The petitioner's physical therapist, consistent with the opinion of all the petitioner's other health care providers, has explained that the petitioner's need for the more expensive lift stems from the fact that he has severe muscle rigidity and is now too big for his caregivers to safely lift him manually. A standard lift uses a sling that is placed under the patient's buttocks and is then attached to the lift mechanism for lifting and transferring the patient. The sling itself is bulky and cannot remain under a person like the petitioner, who uses a molded seat when he is seated in his wheelchair; and once the petitioner is seated, a sling could only be removed by manually lifting him off of it and repositioning him in his chair. Because of the petitioner's size and limitations, his caregivers consider it dangerous for them to singly attempt transfers of the petitioner using a standard sling-type lifter.

The type of lifter sought by the petitioner uses a thoracic strap to secure the patient and can then be operated using a wall-mounted motorized mechanism. Thus, one person could safely and securely accomplish the petitioner's transfers without the need to manually lift him to secure and remove the strap or to reposition him in his chair. It was explained that wall mounts could be placed in more than one place in the petitioner's home, and that one person could easily transfer the lift mechanism from place to place as needed.

The opinions of the petitioner's caregivers are essentially uncontroverted. Based on that documentation it is found that given the petitioner's present circumstances a standard sling-type lifter offers the petitioner only limited medical benefit, and that if only one caregiver is present its use would pose a risk to the safety of the petitioner's caregiver because of the necessity to lift and reposition the petitioner manually. There is no question, based on the evidence presented, that a thoracic-type motorized lifter would meet all the petitioner's needs for safe and efficient transfers with one care provider.

On the other hand, however, although it would be less convenient and, perhaps, not as cost effective, it has not been shown that the petitioner would not receive full or near-full medical benefit from a standard sling-type lifter

provided there were at least two persons present when he was being transferred. The evidence submitted by the petitioner suggests that his ability to remain in a home setting may be imperiled if he does not have access to a motorized lifter. However, except to inform the hearing officer that the case could not be "settled" along these lines, the parties have not responded to the hearing officer's suggestion that the regulations appear to allow Medicaid coverage for the petitioner to have more than one health care provider in the home or for him to rent a motorized lifter if his home health care providers were to purchase one and make it available to him.⁽¹⁾

ORDER

The Department's decision is affirmed.

REASONS

Medicaid Manual (MM) § M841 provides that "patient lifts" are covered under Medicaid as "durable medical equipment". Section M842 includes the following:

Durable Medical Equipment, Purchase Or Rental

The Medicaid Division or its designee will make the decision to rent or purchase durable medical equipment depending upon the estimated period of medical need. Payment, whether rental or purchase, will be based on reasonable charge as developed for Medicare for standard wheelchairs and standard hospital beds. Reimbursement for other items will be based on the lower of the provider's actual charge or the Medicaid reimbursement rate on file.

Equipment may be purchased in the following ways:

By an initial payment equal to the lower of the actual charge or the Medicaid reimbursement rate on file on the date of service for purchases. . . .

In this case, the parties agree that the "Medicaid reimbursement rate on file" at the Department for "patient lifts" is \$913.75. The Department maintains (and there is no evidence to the contrary) that this rate was set according to 85 percent of the average retail price of a standard "Hoyer" sling-type lifter, and that this reimbursement rate has been sufficient to enable most Medicaid recipients who have requested patient lifts to purchase them. In this case, the Department is willing to contribute \$913.75 toward the price of the particular lift recommended for the petitioner, but the Department does not dispute that this amount would not be sufficient to enable the petitioner to purchase such a lift without further funding from another source.

However, as noted above, neither party has offered any representation as to whether in fact the petitioner could have available to him either another personal attendant or a motorized lifter purchased by his health care provider and rented to him by the provider for use in his home. Thus, it cannot be found that the petitioner requires the direct purchase of a motorized lifter in order to sufficiently meet his medical needs. Even if this could be found, however, it cannot be concluded that the petitioner has set forth a sufficient legal basis to overrule the Department's decision in this matter.

The petitioner makes two legal arguments against the Department's "cap" of \$913.75 for patient lifts as it applies to his situation. The first is that the cap violates federal statute and regulations requiring that a state's Medicaid payment rate to be "consistent with efficiency, economy, and quality of care" and to be "sufficient to enlist enough providers so that care and services are available...at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a (a)(30)(A) and 42 C.F.R. § 447.204. It has been held that the "sufficiency" of state Medicaid rates under this provision in the federal statute and regulations is to be measured against the payments that a provider can demand from non-Medicaid patients for a particular service or product, and that a state's coverage is sufficient if it prevents a "disparity" between the services and products available to Medicaid and non-Medicaid recipients. See e.g., King by King v. Sullivan, 776 F. Supp. 645,654-655 [D.R.I. 1991]).

The petitioner also argues that the cap imposed by the Department violates the federal provision that Medicaid services must be "sufficient in amount, duration, and scope to reasonably achieve its purpose". 42 C.F.R. § 440.230(b). In this regard, it has been held that a service is sufficient in amount, duration, and scope if it "adequately meets the needs of most individuals who are eligible for Medicaid assistance to pay for that service". King by King v. Fallon, 801 F.Supp. 925,933 (D.R.I. 1992, emphasis in the original).

In determining whether the Department's cap violates either or both of the above federal requirements, the critical issue is determining what the above federal provisions mean when they refer to a "service".

The petitioner maintains that the "service" in question in this matter must include motorized thoracic-type lifters. Thus, the petitioner argues, because the Department's Medicaid reimbursement rates are not sufficient for recipients who need this type of "patient lift" to purchase them, the payment cap of \$913.75 violates the above federal provisions regarding the enlistment of providers and amount, scope, and duration.

The petitioner further maintains that by excluding anything but standard Hoyer, or sling-type, lifters from its market analysis, the Department's reimbursement rate (based on 85% of average list price of sling-type lifters) is not adequate under the above federal provisions to ensure the petitioner, and others like him, access to the type of service he requires.

Although the Board is presently considering the appeals of the petitioner and one other individual⁽²⁾ who have requested thoracic-type lifters, there has been no evidence presented as to the number of such requests the Department has received over the years, and no evidence as to the percentage that such requests comprise of the total amount of requests for Medicaid coverage of a "patient lift". Based on the Department's representations, and inferences drawn from the testimony of the petitioner's health care providers, it appears that thoracic-type lifters for home use are relatively new in terms of availability and recommended use. If, as it appears from the limited evidence presented, that persons with a medical need for a thoracic-type lifter, as opposed to a sling-type, are few and far between, it cannot be concluded as a matter of law that the Department's cap of \$913.75, which effectively limits Medicaid coverage to sling-type lifters, is insufficient to enlist an adequate number of providers of "patient lifts" or to provide the amount, duration, and scope of "service" necessary for "most" recipients who require those lifts. See King, supra.

To hold otherwise would effectively negate the Department's ability to set coverage limits on any type of medical service that might be subject to unforeseen technological advances that benefit only a very few recipients, and which are much more expensive than the scope of the service as it was contemplated when its reimbursement caps were set. Indeed, this is one of the primary justifications for setting coverage limitations--to prevent the extraordinary needs of a relatively few recipients from swallowing and diverting limited resources that in the state's judgement could be better used serving a greater number of recipients in an amount, duration, and scope necessary to meet their medical needs. These are often difficult and controversial decisions, which may impact harshly on certain recipients whose medical needs cannot be met within the spending limitations imposed by the state. However, states are specifically allowed under the federal statutes and regulations to limit and allocate scarce resources as long as "the best interests of the recipients", as a whole, are served. 42 U.S.C. § 1396a(a)(19); Alexander v. Choate, 469 U.S. 287, 303 (1985).⁽³⁾

This does not mean that the Department's limitation of coverage for medical services can be arbitrary or ad hoc. The Board has held that when the Department's regulations defining a particular covered service are general and open-ended, the Department cannot deny coverage when an unanticipated technological innovation, however expensive, that is within the regulatory definition of that service becomes available to a recipient with a demonstrable medical need for it. See e.g., Fair Hearing Nos. 14,237 and 13,296. In those cases, however, the Board noted that the Department could, if it chose to do so, impose service limitations by regulation. When, as here, the Department's regulations already specify a clear and unequivocal limitation on a particular service, that limitation must be upheld absent a showing that it violates federal provisions to the contrary.

To prevail in an argument that a limitation on a specific medical service renders that service "insufficient" under federal law in amount, duration, and/or scope a recipient must show that the medical needs of a substantial number of individuals are not being met due to the limitation. See King, supra. The Board need not specify what number or percentage of individuals eligible for that service must be found to have an unmet need before a limitation would be found to be violative of federal "sufficiency" provisions. At this time the Board knows of only two individuals, including the petitioner herein, who have ever applied for, and been denied, full payment for a thoracic-type lifter. This fact, alone, is insufficient to conclude that the Department's price cap on "patient lifts" does not meet the amount, duration, or scope of the needs of "most" recipients who are eligible to receive that service.⁽⁴⁾

For all the above reasons the Department's decision in this matter is affirmed.

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1. See Medicaid Manual § M710.
2. See Fair Hearing No. 14,033.
3. The Alexander case upheld Tennessee's 14-day Medicaid coverage limit for hospital stays for certain procedures, even though individual recipients demonstrated that they required longer stays.
4. The petitioner is free to reapply for coverage if he can show that he has no reasonable medical alternative except the direct purchase of a motorized lifter and that the Department's \$913.75 cap does not meet the needs of "most" individuals who need "patient lifts".