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**STATE OF MINNESOTA
IN COURT OF APPEALS
A08-0048**

Tammy Sue Holl,
Appellant,

vs.

Itasca County Health and Human Services,
Respondent,

Minnesota Department of Human Services,
Respondent.

**Filed September 16, 2008
Affirmed
Toussaint, Chief Judge**

Itasca County District Court
File No. 31-CV-07-1891

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Considered and decided by Schellhas, Presiding Judge; Toussaint, Chief Judge;
and Hudson, Judge.

UNPUBLISHED OPINION

TOUSSAINT, Chief Judge

Appellant Tammy Sue Holl challenges the decision by respondent Minnesota Department of Human Services (the commissioner) to deny her medical-assistance coverage for a residential treatment program for nicotine dependence, in an appeal from an adverse decision by the district court. Respondent Itasca County Health and Human Services did not file a brief but joins in the brief submitted by the commissioner. Because substantial evidence supports the decision by the commissioner and because Holl cannot prevail on her constitutional claims, we affirm.

FACTS

Holl resides in Itasca County and is eligible for medical assistance. Itasca Medical Care (IMCare) provides her health care through a contract with the department of human services. Holl was diagnosed with chronic obstructive pulmonary disease, also known as emphysema, in December 2005. At that time, she smoked over two packs of cigarettes a day and had been smoking for nearly 35 years.

IMCare approved a referral for Holl to be evaluated at the Mayo Clinic in Rochester for unexplained weight loss and malnutrition, where she was diagnosed, in relevant part, with emphysema and nicotine dependence. She consulted with a physician at the Mayo Clinic's Nicotine Dependence Center in December 2005, who told her she needed to quit smoking. He recommended the use of nicotine-replacement medication as well as behavioral changes to help her to stop smoking. He also informed her about the center's eight-day residential treatment program for nicotine dependence.

Holl followed the recommended steps but was still unable to quit smoking. Holl then saw her IMCare health-care provider and requested a referral to enter the residential treatment program so that the treatment would be covered by medical assistance. The health-care provider agreed to look into the program. She also prescribed Chantix, a newly approved non-nicotine medication used to help adults quit smoking. With that medication, Holl was able to reduce her daily smoking by half a pack per day but was still unable to quit completely.

On October 31, 2006, Holl made a written request for approval of a referral to the residential treatment program. The medical director of IMCare advised Holl by letter the next day that IMCare would review the medical necessity of the residential treatment program. He also advised that the \$500 lifetime limit on tobacco-cessation products would be waived so that she could continue with the use of Chantix.

Holl then obtained an additional referral to the Mayo Clinic for a further assessment of her nicotine dependence after she contacted the state ombudsman. Dr. Michael Krowka, who examined her, stated: "I fully support every effort to put [Holl] into the inpatient chemical dependence program for nicotine withdrawal management," noting that she could be a candidate for a lung transplant if she stopped smoking and was free from her nicotine dependency.

On November 28, 2006, IMCare advised Holl that it would not approve a referral to the Mayo Clinic's residential treatment program. On November 30, 2006, Holl met again with her health-care provider, still seeking approval for a referral. The health-care provider noted that Holl was currently using a number of means in her attempt to quit

smoking through IMCare, including biofeedback, listening to “Freedom from Smoking” compact discs twice a day, visualization, Chantix, a support program for quitting smoking, and counseling for anxiety and stress. The health-care provider cited concerns that the triggers to smoking that existed in Holl’s living environment needed to be addressed. The health-care provider also felt that the difference in the success rate between the residential treatment program and the treatment that Holl was already receiving from her clinic did not make the residential treatment program worth the expense and also addressed Holl’s “will” to quit. Despite IMCare’s refusal to approve the treatment, Holl attended and successfully completed the Mayo Clinic’s residential treatment program in early December 2006.

Holl appealed the denial of coverage, and an administrative hearing was held before a department of human services judge. At the hearing, the medical director of IMCare testified that after weighing information from the department and the Mayo Clinic and considering the options available to Holl at her clinic, IMCare had decided that referral to the residential treatment program was not warranted. He noted that the program’s success rate ranged from 23% to 45% after one year and that the kind of treatment Holl received from her clinic had similar success rates. He also acknowledged that treatment for alcohol addiction, which is paid for by IMCare, is also not very high.

The medical director noted that IMCare waived the \$500 lifetime limit on medications for smoking-cessation products for Holl. Both Holl’s health-care provider and the medical director felt that because Holl’s living environment contained triggers to smoking, Holl would not have a better chance of success with the residential treatment

program than with the options already available to her. Also, use of that program was unprecedented at the department.

The medical director acknowledged that nicotine is an addictive drug but explained that it is in a separate category from other drugs. Holl detailed her earlier unsuccessful efforts to quit, and she described the residential treatment program that she had successfully completed, despite IMCare's refusal to approve payment for it. She explained that this was the first time she had been successful in quitting smoking and that since her attendance at the program she has had only one short relapse.

The department of human services judge ruled that no evidence had been submitted showing that the residential treatment program for nicotine dependence was generally accepted by the medical or chemical-dependency community and thus it had not been shown that it was medically necessary for Holl's treatment. The judge recommended that the commissioner affirm the decision to deny coverage, and the commissioner adopted the recommendation.

Holl challenged the decision in district court pursuant to Minn. Stat. § 256.045, subd. 7 (2006), and she also raised an equal-protection claim. The district court affirmed the decision by the commissioner and rejected Holl's constitutional claim

D E C I S I O N

I.

An appellate court will review an agency's medical-assistance-eligibility determination independently, without deferring to the district court's review. *Estate of Atkinson v. Minn. Dep't of Human Servs.*, 564 N.W.2d 209, 213 (Minn. 1997). The

standard of review in Minn. Stat. § 14.69 (2006) applies. *Johnson v. Minn. Dep't of Human Servs.*, 565 N.W.2d 453, 457 (Minn. App. 1997). The reviewing court may reverse or modify the decision of the agency “if the substantial rights of the petitioners may have been prejudiced because the administrative finding, inferences, conclusion, or decisions are . . . in violation of constitutional provisions; or . . . unsupported by substantial evidence in view of the entire record as submitted” Minn. Stat. § 14.69(a), (e). Substantial evidence means “(1) such relevant evidence as a reasonable mind might accept as adequate to support a conclusion; (2) more than a scintilla of evidence; (3) more than some evidence; (4) more than any evidence; or (5) the evidence considered in its entirety.” *Minn. Ctr. for Env'tl. Advocacy v. Minn. Pollution Control Agency*, 644 N.W.2d 457, 466 (Minn. 2002). This court will defer to agency expertise. *See Reserve Mining Co. v. Herbst*, 256 N.W.2d 808, 824 (Minn. 1977). The party challenging the agency decision has the burden of proving that one of the statutory grounds for reversal exists. *Markwardt v. State Water Res. Bd.*, 254 N.W.2d 371, 374 (Minn. 1977).

For a health service provided to a medical-assistance recipient to be eligible for payment, it must

be determined by prevailing community standards or customary practice and usage to:

- (1) be medically necessary;
- (2) be appropriate and effective for the medical needs of the recipient;
- (3) meet quality and timeliness standards;

(4) be the most cost effective health service available for the medical needs of the recipient;

Minn. R. 9505.0210(A) (2007); *see* Minn. R. 9505.0175, subp. 25 (2007) (defining “medical necessity” as “health service that is consistent with the recipient’s diagnosis or condition and . . . is recognized as the prevailing standard or current practice by the provider’s peer group”).

While not binding on this court, we note initially that the district court concluded that the commissioner’s decision was supported by substantial evidence. We apply the same standard to independently review the commissioner’s decision. *Estate of Atkinson*, 564 N.W.2d at 213.

The commissioner concluded: “No evidence has been submitted showing that inpatient nicotine treatment is generally accepted by the medical or chemical dependency community, and thus it has not been shown that [Holl’s] treatment is medically necessary.” In challenging this ruling, Holl cites the opinion of Dr. Krowka from the Mayo Clinic supporting her attendance at the residential treatment program. She contends that the residential treatment program did represent appropriate community standards, as demonstrated by the fact that IMCare referred her there for an evaluation in December 2005 and by the fact of the Mayo Clinic’s reputation. Holl also argues that no other reasonable treatment existed, that the cost of her medical care in the future, had she continued smoking, would have far outweighed the cost of the residential treatment program, and that it is unfair to fund residential treatment programs for drug and alcohol dependence and not to fund such treatment for nicotine dependence.

To address this issue, we must review whether there is substantial evidence to support the commissioner's findings. *Minn. Ctr. for Env'tl. Advocacy*, 644 N.W.2d at 466. Further, we defer to the agency's expertise. *Reserve Mining*, 256 N.W.2d at 824. Holl's health-care provider and the medical director did not recommend the program, based on the treatment she was already receiving from the clinic and on the fact that the triggers to smoking in her home environment had not yet been resolved. Further, IMCare noted that it had not previously approved a residential treatment program for nicotine dependence and that the program had a success rate of 23-45%, similar to the success rate of the treatment employed by Holl's health-care provider. The commissioner, who is charged with administering the medical-assistance program, has the expertise and specialized knowledge to evaluate the efficacy of the residential treatment program and to determine whether the results warranted the costs involved. Substantial evidence supports the decision of the commissioner and there is no evidence that would satisfy the standards of Minn. R. 9505.0210(A), read either narrowly or broadly, that would show to the contrary.

II.

Next, Holl argues that the denial of coverage for the residential treatment program violates her equal-protection rights under the state and federal constitutions, because medical assistance covers residential treatment for drug and alcohol dependence but does not cover the same treatment for nicotine dependency. This constitutional claim was raised for the first time before the district court, because agencies do not have subject-matter jurisdiction to rule on constitutional issues. *Neeland v. Clearwater Mem'l Hosp.*,

257 N.W.2d 366, 368 (Minn. 1977). The appellate court conducts a de novo review of constitutional issues. *Gluba ex rel. Gluba v. Bitzan & Ohren Masonry*, 735 N.W.2d 713, 719 (Minn. 2007).

The Equal Protection Clause of the United States Constitution provides that no state “shall . . . deny to any person within its jurisdiction the equal protection of the laws.” U.S. Const. amend. XIV, § 1. The Minnesota Constitution provides, in relevant part: “No member of this state shall be disfranchised or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land or the judgment of his peers.” Minn. Const. art. I, § 2. The state and federal equal-protection clauses “have been analyzed under the same principles and begin with the mandate that all similarly situated individuals shall be treated alike, but only invidious discrimination is deemed constitutionally offensive.” *Gluba*, 735 N.W.2d at 719 (quotation omitted). Where, as here, the “constitutional challenge involves neither a suspect classification nor a fundamental right, we review the challenge using a rational basis standard under both the state and federal constitutions.” *Id.*

The two classes at issue are (a) those medical-assistance recipients who are dependent on nicotine; and (b) those medical-assistance recipients who are dependent on drugs or alcohol. “Essential to a ruling that equal protection has been denied by discriminatory administration of the laws is a finding that the persons treated disparately are similarly situated.” *State by Spannaus v. Lutsen Resorts, Inc.*, 310 N.W.2d 495, 497 (Minn. 1981). To withstand an equal-protection challenge, “the difference between classes need not be great, and if any reasonable distinction can be found, a court should

sustain the classification.” *Peterson v. Minn. Dep’t of Labor & Indus.*, 591 N.W.2d 76, 79 (Minn. App. 1999), *review denied* (Minn. May 18, 1999).

Holl argues that there is no real difference between the class of those who are addicted to nicotine and the class of those who are addicted to other drugs. She notes that as the medical director of IMCare testified, these substances are all addictive. She asserts that both have short and long-term negative impacts on health, which could ultimately result in death. But the two classes at issue are not similarly situated merely because harmful addictions are involved in both. As the district court noted, making the determination as to whether residential treatment programs for different kinds of addictions should be covered services for purposes of medical assistance requires the expertise of professionals and agencies charged with administering medical assistance’s finite funds. Further, the distinctions between the types of residential treatment involved can themselves provide a rational basis for the difference in treatment.

Finally, Holl cites several federal court of appeals’ decisions in support of her arguments. *See, e.g., Meusberger v. Palmer*, 900 F.2d 1280, 1282-83 (8th Cir. 1990). These federal cases involve medical-assistance recipients who sought approval for various types of transplants and involve a federal provision not at issue here. Accordingly, they are not relevant.

Holl has not established an equal-protection violation under the state and federal constitutions.

Affirmed.