STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE TRIBUNAL FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],

Appellant
_____/

Docket No. 2009-14928 CMH
Case [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] appeared on behalf of the Appellant; [redacted] is also the legal guardian of the Appellant and testified in that capacity at hearing. [redacted] appeared as a witness on behalf of the Appellant.

[redacted] represented the Department. Also in attendance was [redacted] and [redacted].

ISSUE

Did the Department [redacted] properly deny the Appellant Medicaid covered Outpatient individual mental health therapy?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] duly eligible Medicare and Medicaid beneficiary who has been diagnosed with a serious mental illness. She resides in the community in an apartment.

2. The Appellant has a legal guardian and conservator.

3. [redacted] is a Prepaid Inpatient Health Plan (PIHP) under contract with the

Department of Community Heath (Department) to provide Medicaid covered services to Medicaid beneficiaries who reside in the [redacted] service area. The [redacted] contract with the Department requires [redacted] to provide medically necessary Medicaid covered services and make service authorization decisions for all Medicaid covered services requested by or provided to Medicaid beneficiaries who reside in their service area.

4. The Appellant's most recent DSM-IV diagnosis is as follows: Axis I, Schizophrenia; Axis II, none; Axis III, Hypothyroidism; Axis IV, problem with primary support group, problem related to social environment, economic problems, problems related to behavior/personality; Axis V, GAF of 35. The Appellant has a history of refusing psychiatric medications. She is currently taking Abilify.

5. The Appellant is authorized for Medicaid covered mental health services through [redacted] as a person with a serious persistent mental illness. The Appellant's Individual Plan of Service (IPOS) was completed in [redacted]. She receives case management services through Community Network Services (CNS), a contractor with the PIHP.

6. The Appellant's IPOS authorized a therapy assessment, which was completed. There was no recommendation for individual outpatient mental health therapy made as a result of the assessment.

7. A request from the Appellant's guardian for outpatient mental health therapy treatment through the PIHP was denied. The reasons for denial include the assessment finding that the Appellant was not interested in therapy at the time of the assessment, that she reported participation in outpatient mental health therapy in the community and that she has Medicare benefits which will cover outpatient mental health services if she desires them.

8. The Appellant told the therapist at the assessment she was not interested in therapy at the time, was accessing it in the community and also that she went to the assessment to comply with the guardian. (Department Exhibit A, page 6)

9. The Appellant is a college graduate with a work history. She has been unemployed since a rapid deterioration of her mental status began approximately [redacted].

10. The Appellant's guardian asserts as she has authority to make the medical decisions on behalf to the Appellant, if she believes the Appellant would benefit from therapy it should be provided through the CMH agency. She sought outpatient mental health therapy treatment for the Appellant, through the [redacted] and requested the hearing on her behalf following the denial.

11. The guardian has never sought outpatient mental health treatment from a provider who accepts Medicare on behalf of the Appellant.

12. The Appellant did not attend the hearing.

13. The Appellant's guardian asserts the Appellant lacks insight into her mental illness, thus would benefit from outpatient mental health therapy despite voicing a lack of interest.

14. In [redacted] completed an assessment determining the Appellant is in a pre-contemplation stage and would not benefit from outpatient mental health therapy. A denial notice was sent.

15. The Appellant's guardian requested a formal, administrative hearing upon receipt of the denial notice.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
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> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Community Health (Department) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation & Supports Waiver. [redacted], as a PIHP, is under contract with the Department to provide State Medicaid Plan and waiver services. In [redacted] staff completed a service intake assessment in which it considered the Appellant's eligibility for Medicaid covered outpatient mental health therapy services. [redacted] staff concluded that the Appellant did not meet Medicaid services eligibility criteria for outpatient individual and group mental health services through [redacted].

The Appellant is entitled to Medicaid funded services through [redacted] if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH/CMHSP Managed Specialty Supports and Services Contact: Attachment 3.3.1 and/or 3.3.2.

2. The service in issue is a Medicaid covered service, i.e. State Medicaid Plan or waiver program service, and

3. The service is medically necessary.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.* [redacted] is required to use a person-centered planning process to identify medically necessary services and how those needs would be met. The person-centered planning process is designed to provide beneficiaries with a "person centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

The Appellant's most recent IPOS included authorization for case management services and a therapy assessment. The IPOS was signed by the guardian. The therapy assessment authorized in the IPOS was not timely, however, it did get completed and formal, written notice was eventually provided to the Appellant. The [redacted] concluded, following the [redacted]

[redacted] therapy assessment, that the Appellant did not have a medical need for outpatient mental health therapy at that time. The request for coverage of the aforementioned treatment was denied. This denial of the Appellant's request for Medicaid covered services gave rise to the Appellant's fair hearing rights and her appeal of the [redacted] action.

The parties do not dispute the Appellant's continued eligibility as a person with a serious persistent mental illness, for [redacted] authorized Medicaid covered services. There is a disagreement on the medical necessity for outpatient mental health therapy. (This ALJ notes despite the lack of agreement regarding whether the Appellant needs outpatient mental health therapy at this time, there is no dispute that Medicaid is a payer of last resort. The Appellant's guardian stipulated she had never sought Medicare coverage for outpatient mental health therapy on behalf of the Appellant. She could do so at any time.) Despite the fact the Appellant is able to access Medicare covered outpatient mental health therapy at any time with a provider who accepts Medicare, the issue before this ALJ is whether the [redacted] has denied a medically necessary Medicaid covered service. The [redacted] asserts it has not as outpatient mental health therapy was not medically necessary for the Appellant at the time of the assessment. The contract between CMH and the Department defines medical necessity:

> **3.2 Medical Necessity**
>
> The PIHP will use, for Medicaid beneficiaries, the medical necessity criteria specified by MDCH and reflected in Attachment P 3.2.1. **Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.** (Emphasis added by ALJ). In addition, the PIHP must also consider social services and community supports that are crucial for full participation in community life, must apply person-centered planning for individuals with mental health needs, and must consider environmental factors and other available resources that might address the situation. The criteria are intended to ensure appropriate access to care, to protect the rights of individuals and to facilitate an appropriate matching of supports and services to individual needs. (Emphasis added).
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> *Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 03-04, Section 3.2, page 27.*

In this case the clinical opinion of the [redacted], was formed following review of the assessment summary. An assessment was completed in [redacted]. At the assessment the Appellant stated she was seeing a psychotherapist at the [redacted]. Additionally, she reported an anxiety level of 5 (10 being highest),

self esteem at 6. She further stated she did not "see the point" of talk therapy. She denied suicidal/homicidal ideation, plan or intent. She stated she has stable moods and her emotions are in check. She stated she did not believe she needed therapy but would attend only to comply with her guardian/conservator. Based upon this interaction with the Appellant and other tools used with the Appellant, which included a LOCUS assessment resulting in a score of 18, it was determined she has no medical necessity for individual therapy. The summary includes the following determination:

> *[redacted] has no interest in therapy at this time. [redacted] presents in the pre-contemplation stage of change for mental health & there are no indications of a substance abuse problem. She attended the interview to be in compliance with the request of the guardian/conservator. Therapy is not recommended at this time. The representative of the guardian/conservator requested a copy of this assessment.*

The witness testifying on behalf of [redacted] also reviewed the Level of Care Determination Matrix for the Appellant. A copy of the matrix was included in the evidence. It assesses in 6 dimensions and assigns a score, which is the total of the score received in each dimension. The Appellant scored an 18, resulting in a disability designation of MI and a service designation MI. The level of service marked is CSM, denoting a score between 14-21. Specifically, the matrix indicates the Appellant as a low level of risk in dimension I. Her low risk level was supported by the fact she has never attempted suicide, denies intent or plan to harm herself in the past or currently. Dimension 2 indicates she was found moderately impaired based upon completion of a 4 year degree at [redacted], past employment at a bank 4 or 5 years ago. Dimension 3 is co-morbidity. She has no co-morbidity. There was no history of alcohol abuse, sleep and appetite are reportedly adequate. She complained of lack of transportation and boredom. Dimension 4a is for Recovery Environment-Stress. She was determined to have a moderately severe level of stress. She rated it average herself when asked. She stated she had never been abused or neglected and complained of insufficient income. She denied legal issues. Dimension 4b is Recovery Environment-support. She has a limited level of support since both of her parents are deceased. She gets emotional support from nieces and nephews. She does not involve herself in community groups, such as church, or other worship. She has a conservator and legal guardian. Dimension 5 is Treatment and Recovery History. She was determined to have a moderate or equivocal response to treatment and recovery based upon her lack of memory of the psychiatric medication she is taking or has taken in the past. Additionally, she reports forgetting to take her medication every day. She has a history of non-compliance and taking herself off medication. Dimension 6 is Attitude and Engagement. She was determined to have an obstructive Attitude and Engagement based upon her lack of insight into her mental illness, treatment issues or goals. It was noted she does not appear interested in treatment. She is guarded, vague and a poor historian. She showed interest in social opportunities and clubhouse.

The interpretive summary includes the following pertinent information:

> *(The Appellant) is a [redacted], divorced female… her guardian, conservator contacted [redacted] to inquire about reopening (her) case with [redacted]. The rationale of the guardian was that (she) has not taken psychiatric medication since [redacted] and she is decompensating. (She) was originally scheduled for an intake appointment 1 month ago. (She) showed up for the intake appointment but left before the intake worker was able to make contact with her. Once (she) had arrived to the office, she decided she no longer was interested in services. In an effort to engage (her) in services, it was decided that a home visit would be the most effective approach.*
>
> *(she) is a poor historian and was unable to provide any significant or detailed amounts of information pertaining to her mental illness. (she) reports the first time she received mental health treatment was 2 or 3 years ago. She has had 3 psychiatric hospitalizations and denies ever attempting suicide. (She) has a 4 year degree and has many held (sic) several jobs throughout her life.*
>
> *(she) has some family support in her life, but tends to isolate herself from them. (She) does not have any involvement in the community and complained "I don't have much to do". (She) has a caregiver that stops by her apartment a couple times a week, but that appears to be the only social interaction (she) has. It appears that (she), not too long ago, has a fully functional life, but has deteriorated rather quickly. Reports from the guardian state that (she) is argumentative, isolative, is refusing to take her thyroid medication, and is not capable of adequately taking care of herself. (She) has very little motivation and limited insight into her mental illness. (She) will benefit from medication, case management, and different social opportunities that are available through [redacted]. (She) did express an interest in the [redacted]. Barriers to her treatment are lack of insight and noncompliance with treatment in the past. Her biggest strengths are her desire to become socially involved in the community and support from her guardian and caregiver.*
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> *Level of Care Determination Matrix Summary dated 5/7/2008.*

The Appellant's guardian asserts she has authority to make medical decisions for the Appellant because she has been appointed as the guardian. She further asserts the Appellant lacks insight into her illness, refused her medications and deteriorated to the point of requiring a legal guardian with authority to make medical decisions on her behalf. She asserts the Appellant is incapable of making her own medical decisions, thus her statements should not used to deny her necessary services. She asserts the Appellant's lack of insight should not be used against her to deny necessary services. She called witness [redacted] to provide evidence that it took several contacts with the Appellant to establish sufficient trust to begin a working relationship with her. The Appellant's guardian asserts even though the Appellant expresses that she sees no value in talk therapy, she would eventually benefit from it as she has benefited from the services provided by [redacted], with whom she would not cooperate at first.

This ALJ carefully considered all evidence of record, including the therapy assessment, testimony from the legal guardian, case record notes included by [redacted] and testimony directly from [redacted]. The clinical judgment of the contracted providers is found credible and persuasive by this ALJ. This ALJ does agree with the Appellant's attorney that a person should not be denied medically necessary services simply because they lack insight into their mental illness. However, this valid point did not establish the denial of individual therapy is a denial of a medically necessary service for this Appellant at this time. The assessment, when finally conducted, was thorough and the opinion reached was supported by competent evidence. This ALJ did not find sufficient evidence in the record to find the [redacted] erred in its determination to deny the requested services. Additionally, **if** it is the assertion from the Appellant's legal guardian that her judgment of what is medically necessary supersedes that of the state contracted providers simply because she was appointed as legal guardian she is mistaken. She is possessed of legal authority to make medical decisions for the Appellant. Her advocacy on behalf of the Appellant is considered, however, the authority granted as guardian does not extend to authority over [redacted]. She still carries a burden of proof to establish the determination to deny outpatient mental health therapy was incorrect. This ALJ is not convinced the Appellant's guardian was asserting her position as guardian vests her with the authority to demand [redacted] provide outpatient mental health therapy, however, addresses it here for clarification purposes.

There was much testimony regarding the fact the Appellant has Medicare and Medicaid. The determination of [redacted] was that the requested services were not medically necessary, thus they were denied. There is no evidence in the record the Appellant was denied a medically necessary service solely because she is eligible for Medicare. The evidence of record establishes it was a clinical determination she did not require and would not benefit from the services requested that ultimately resulted in a denial. This is the only material issue for this ALJ to decide at hearing. The concerns raised regarding the tardiness of the therapy assessment and delay in providing a written notice were rendered moot given that the assessment was completed, the notice sent and the hearing requested and held. No additional findings need be made or orders issued regarding the other issues raised by the Appellant because they are moot.

DECISION AND ORDER

The [redacted] provided sufficient credible evidence the denial of outpatient mental health therapy was appropriate as not medically necessary.

IT IS THEREFORE ORDERED that:

The Department's decision is UPHELD.

_____

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2009-14928 CMH
Decision and Order

cc: [redacted]

Date Mailed: 5/29/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.