STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

,
Appellant

_______________________/

Docket No. 2009-17365 CMH
Case No.
Load

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 on . , appeared on behalf of the Appellant. She had no witnesses. 0, represented the Department. His witnesses were , .

ISSUE

Did the properly deny services to the Appellant?

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 disabled Medicaid beneficiary.

2. He is enrolled in CSHCS and receives an array of surgical services relating to a birth defect. (*See* Appellant's Exhibit #1 and *see* Testimony)

3. The Appellant was recently convicted of and "ordered" by the local circuit court to obtain counseling. (See Testimony and Appellant's Exhibit #1).

4. Appellant lives in , Michigan and has a limited selection of mental health care providers available. To date the Appellant's representative has been unable to secure a provider.

5. The Appellant's grandmother/representative seeks services for her grandson – who she suspects to be developmentally disabled – although there is no evidence to support that diagnosis. (See Testimony and Department's Exhibit A – throughout).

6. The Applicant provided no circuit court order mandating counseling as part of the Appellant's sentencing.

7. The Appellant's grandmother/representative admitted that they were directed to the county probation department] by the circuit court - but they have not made contact. (See Testimony)

8. On , the Appellant was assessed by and found to be not eligible for services owing to a lack of medical necessity. (See Testimony and Department's Exhibit A, p. 8)

9. The Appellant was diagnosed as having impulse control disorder NOS – but otherwise self reported minimal symptoms. There was no severe persistent mental illness. (Department's Exhibit A, pp. 7, 30)

10. There was no DD diagnosis. (See Testimony and Department's Exhibit A, p. 5)

11. for the of Michigan is under contract with the Michigan Department of Community Health (Department) to provide mental health services to those who reside in the Appellant's geographic area.

12. The Appellant currently has no access to independent counseling services owing to his . (*See* Testimony)

13. The Appellant was noticed of the denial by Adequate Notice Denial on his further appeal rights were described therein. (Department's Exhibit A, pp.18-34)

14. The instant appeal was received by SOAHR on . (Appellant's Exhibit #1)

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

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…

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

> The Secretary may by waiver provide that a State plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The NorthCare Network Community Mental Health for the Upper Peninsula, Michigan (the Department) contracts with the Michigan Department of Community Health to provide those services.

Medicaid Beneficiaries are entitled to services when the following conditions are met:

1. They meet the service eligibility requirements per the Medicaid Managed Specialty Supports and Services Contract: Attachment 3.3.2.

2. The service at issue is a Medicaid covered service; i.e. State Medicaid plan or Waiver program service, and

3. The service is medically necessary.

While it is axiomatic that Medicaid is the payer of last resort the CMH is the entry point for treatment of serious and persistent mental illness. The service criteria for this capitated provider is medical necessity. *Supra*

In this case the Department witness, agreed that the Appellant was an individual who might benefit from counseling, but agreed with the CMH assessment and evaluation which found no in the Appellant.

Although it was learned that the Appellant has CSHCS coverage the crux of the Appellant's dilemma is that he cannot find a provider to receive recommended counseling services on referral because he is not in a MHP. At present the Appellant cannot switch from a setting to because of significant previously scheduled surgeries and because he is excluded from managed care by his enrollment in CSHCS.

In performing the terms of its contract with the Department, the /Community Mental Health (CMH), must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or

- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP
Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A [redacted] may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis. (Emphasis supplied)

MPM, Mental Health [ ];
§2.5 pp. 12-14, April 1, 2009

* * *

The testimony established that the Appellant would likely benefit from counseling – but that he does not suffer from a SPMI or DD. The Appellant's representative admitted on the record that the Appellant has not contacted the county probation department to determine availability of services and whether they are in fact part of the Appellant's sentence – or just a reasonable suggestion.

No order was received from the circuit court.

Normally it is the responsibility of the county to provide mental health services to those incarcerated in its jails[1] – however the exact post conviction status of the Appellant is unknown at this writing.

[1] OAG, No. 7231 [p.] (May 27, 2009)

Incarceration or probation aside it was clear from the detailed assessment conducted by [redacted] that the Appellant was not eligible for [redacted] medically necessary services. That he might benefit from counseling cannot be denied, but the mental health professionals assessing the Appellant to date found no eligibility for medically necessary treatment of a [redacted]. [See Testimony of Dr. Cool]

The CMH properly acknowledged and performed their role as the entry point for mental health services. The Appellant was properly assessed and when found not to be afflicted with [redacted] or [redacted] the Appellant was referred for other less restrictive services.

Absent evidence that the Appellant suffers from a more serious mental impairment the CMH properly denied service.

The Appellant has not preponderated his burden of proof that he is afflicted with a serious mental illness. There was no evidence to show that the Appellant has need for CMH services based on his [redacted], assessment.

The Department's action was proper when made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied access to services.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIMED.

Dale Malewska
Administrative Law Judge
For Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/30/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.