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

IN THE MATTER OF:

[redacted],

Appellant

_____/

Docket No. 2009-19259 CMH
Case 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 on [redacted]. [redacted], Inc., represented the Appellant. [redacted], testified as witnesses for the Appellant. Representative appeared and testified on Appellant's behalf. [redacted]r, represented the Department's agent, [redacted]lth Psychiatrist, testified as a witness for the Department.

ISSUE

Does Appellant meet the MDCH/CMHSP Managed Specialty Supports and Services Contract Medicaid service eligibility requirements for Medicaid-covered specialized mental health services?

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] year-old Medicaid beneficiary who received Community Mental Health (CMH) services in [redacted]. (Appellant Exhibit 1)

2. Appellant has a history of a seizure disorder, hypertension, chronic alcoholism, coronary artery disease, heart attack, PUD & GI bleed, peripheral neuropathy, cerebral atrophy, mood disorder & depression, psychosis, and Dementia secondary to alcohol abuse. (Appellant Exhibit 1, p. 13)

3. [redacted] is the Pre-paid Inpatient Health Plan (PIHP) and Community Mental Health Service Provider (CMHSP) who contracts with the Michigan Department of Community Health to provide both Medicaid and non-Medicaid funded mental health services to Medicaid beneficiaries.

4. According to a Preadmission Screening Annual Resident Review (PASARR) Level I Screening report dated [redacted], Appellant has a history of depression - "not well documented." (Appellant Exhibit 1, p. 31)

5. Appellant has been receiving inpatient psychiatric services from [redacted] since in or about [redacted].

6. According to an OBRA PASARR Progress Note dated [redacted], it was determined that: Appellant's primary diagnosis is related to a long history of alcohol dependence as opposed to active mood issues; it was not appropriate for Appellant to be placed in a nursing home, and his needs would best be met in a facility that specializes in traumatic brain injuries; and depending on Appellant's cognition, it was recommended that he continue substance abuse treatment and close monitoring for the emergence of mood symptoms. (Appellant Exhibit 1, pp. 33-35)

7. According to a History and Physical Report from [redacted] dated [redacted]: Appellant was admitted to the emergency room by the nursing home because he was very agitated, aggressive, paranoid, and acting out, and he had become physically assaultive in the last few days; Appellant was not relaxed, nor friendly during conversation, and he seemed to be quite paranoid and suspicious; Appellant denied hallucinations; Appellant seemed to be walking very slow with a somewhat unsteady stiff gait, and Appellant could not explain why he was walking that way; and Appellant was given an Axis I diagnosis of Dementia, secondary to chronic alcoholism, possible Korsakoff/encephalopathy; and chronic alcoholism. (Appellant Exhibit 1, p. 43)

8. According to a Consultation report from [redacted] System: Appellant was admitted to the psychiatric floor of the hospital, on

9. [redacted], due to Dementia secondary to alcoholism and alcoholic encephalopathy; and he had fallen several times. (Appellant Exhibit 1, p. 47)

10. According to a [redacted] Consultation Report dated [redacted]: Appellant has a "history of depression in the past, maybe bipolar mood disorder, however, patient also has history of alcoholism and ended up having seizures"; Appellant's mental status examination revealed that he did not seem to be oriented to time, place, and person; Appellant was screaming and yelling, and he was not able to answer any of the examiners questions in a meaningful way; Appellant did not appear to have any cognitive skills to recognize the need for treatment or any medical or physical needs; and Appellant was given an Axis I diagnosis of a psychotic disorder NOS, rule out mood disorder NOS, history of alcohol. (Appellant Exhibit 1, p. 82)

11. On or about [redacted], Appellant applied for [redacted] Medicaid-covered specialized mental health services. (Appellant Exhibit 1, p. 13)

12. During the [redacted] intake process, Appellant was given an Axis I diagnosis of Dementia NOS and Alcohol Dependence. (Appellant Exhibit 1, p. 23)

13. The [redacted] Psychiatrist determined that: there is no historical evidence that Appellant has a psychotic spectrum illness or any significant progressive mood disorder; there is no evidence of Appellant having violent or aggressive behavior; and the only consistently recorded Axis I diagnosis for Appellant is alcohol dependence or related cognitive complications. (Appellant Exhibit 1, p. 29)

14. On [redacted] provided Appellant with an Adequate Action Notice, stating that his request for [redacted] mental health services was denied on the basis that Appellant does not have a qualifying diagnosis. (Appellant Exhibit 1, pp. 1 & 2)

15. [redacted] received a Request for Second Opinion/Denial of Hospitalization or Other Services filed on Appellant's behalf. (Appellant Exhibit 1, p. 4)

16. On March 9, 2009, [redacted] denied Appellant's request for [redacted] mental health services again on the basis that Appellant does not have a qualifying diagnosis. (Appellant Exhibit 1, p. 5)

17. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for hearing, protesting the denial of CMH services on the basis that Appellant does not have a qualifying diagnosis.

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.
>
> *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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. NorthCare contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by the CMH agency pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible. 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.*

The *MDCH/CMHSP Managed Specialty Supports and Services Contract* (the Contract)*: Attachment 3.3.2, 10/1/02, page 35,* makes the distinction that a person must have a persistent mental illness and/or severe emotional disturbance, as opposed to having only mild or moderate psychiatric symptoms, in order to be eligible to receive Medicaid specialized mental health services through a CMHSP. In the Contract, persistent mental illness and severe emotional disturbance are defined by:

> diagnosis and degree of disability, or
> diagnosis and duration of illness, or
> diagnosis and prior service utilization criteria.

The Department's Contract with the CMH sets out the eligibility requirements for Medicaid specialized ambulatory mental health benefits. Severe and Persistent Mental Illness is defined in the Contract as:

> **1. <u>Diagnoses</u> as defined by Diagnostic and Statistical Manual-IV Version (DSM-IV) - Schizophrenia and Other Psychotic Disorder (295.xx; 297.1; 297.3: 298.8: 298.9), Mood Disorders, or Major Depressions and Bipolar Disorders 296.xx).**
>
> 2. <u>Degree of Disability</u>-Substantial disability/ functional impairment in three of more primary aspects of daily living such that self-sufficiency is markedly reduced. This includes:

Personal hygiene and self-care,
Self-direction,
Activities of daily living,
Learning and recreation, or
Social transactions and interpersonal relationships.

In older persons (55 or older), loss of functional capacity might also include:

Loss of mobility.
Sensory impairment,
Physical stamina to perform activities of daily living or ability to communicate
Immediate needs as the result of medical conditions requiring professional supervision, or
conditions resulting from long-term institutionalization.

Duration-

a) evidence of six continuous months of illness, symptomatogy, or dysfunction, or six cumulative months of symptomatology/dysfunction in a 12-month period, or

b) based on current conditions and diagnosis, there is a reasonable expectation that the symptoms/dysfunctions will continue for more than six months.

Prior Service Utilization-

a) four or more admissions to a community inpatient unit/facility in a calendar year, or
b) community inpatient hospital days of care in a calendar year exceeding 30 days, or
c) State hospital utilization of over 60 days in a calendar year, or
d) Utilization of over 20 mental health visits (e.g., individual or group therapy) in a calendar year.

MDCH/CMHSP Managed Specialty Supports and Services Contract: Attachment 3.3.2, 10/1/02, pages 35-36.

The Appellant sought Medicaid covered mental health services through [redacted]. The [redacted] Psychiatrist determined that: there is no historical evidence that Appellant has a psychotic spectrum illness or any significant progressive mood disorder; there is no evidence of Appellant having violent or aggressive behavior; and the only consistently recorded Axis I diagnosis for Appellant is alcohol dependence or related cognitive complications.

Appellant's representative argued that Appellant does have a serious mental illness and is in need of CMH services. It was argued that Appellant needs assistance out an acute-care hospital in a less restrictive environment where he can get the behavioral health services that he needs, and [redacted] should have completed the Person-Centered Planning process to determine the CMH services that Appellant needs. In addition, Appellant's representative stated that long-term residential treatment was not requested on Appellant's behalf.

Appellant's representative argued further that Appellant has a serious mental illness or an Axis I qualifying diagnosis of Dementia with delusion, Dementia with depressed mood and/or Dementia with behavioral disturbance, and a significant functional disability. Appellant's witness, Dr. Larson, testified that Appellant has made dramatic improvement in the last 3 or 4 weeks prior to the hearing; however, he is still in need of psychiatric treatment. Dr. Larson testified that Appellant has Dementia with a behavioral disturbance. According to Dr. Larson, Appellant has cognitive difficulties and his behavioral problems include aggression and outbursts, but Appellant is capable of being rehabilitated through psychiatric intervention. Appellant's witness, Dr. Harrison, testified that Appellant has benefited from psychiatric treatment, and there are many contributing factors to his Dementia; and Appellant's mental health problems include a behavioral disturbance, delusions and deliriums. Dr. Harrison testified that Appellant does not belong in an acute-care hospital. He opined that Appellant needs to be in a less restrictive structured environment such as a nursing home or adult foster care home where he can receive psychiatric treatment. Appellant's witness, Mr. Ziebart, testified that his staff has been trying to find appropriate placement for Appellant who requires 24-hour care, and [redacted] has only provided suggestions on placement that might be appropriate for Appellant. Appellant's witness, Ms. Blake, testified that Appellant has behavioral issues due to Dementia, and she is hopeful that Appellant will be successful in a less restrictive setting with supportive services from CMH.

[redacted] denied Appellant's request for mental health services on the basis that he does not have a qualifying diagnosis. The only issue to be resolved by this Administrative Law Judge is whether [redacted] properly determined that Appellant did not meet the eligibility criteria for Medicaid-covered specialized mental health services. Appellant had the burden of proving by a preponderance of evidence that he met the eligibility criteria for Medicaid-covered specialized mental health services at the time relevant to this matter.

This Administrative Law Judge must uphold the denial of **Medicaid-covered** specialized mental health services. Dementia or Dementia due to Multiple Etiologies is not included on the qualifying diagnosis Contract list **for Medicaid beneficiaries**. According to the *MDCH/CMHSP Managed Specialty Supports and Services Contract* (the Contract) a person is considered to have a severe persistent mental illness if diagnosed with **Schizophrenia and Other Psychotic Disorders (295.xx; 297.1; 297.3; 298.8; 298.9), Mood Disorders, or Major Depressions and Bipolar Disorders (296.xx).** Appellant's diagnosis of Dementia is explicitly excluded from the Contract qualifying diagnosis list for Medicaid beneficiaries. Therefore, the CMH is unequivocally prohibited from using **Medicaid funds** to provide specialty services and supports services to the Appellant on the basis that he was given that Axis I diagnosis of Dementia with behavioral concerns.

Appellant was given an Axis I diagnosis of Psychosis-NOS. However, this Administrative Law Judge agrees with [redacted]s determination that at the time of the eligibility determination, Appellant provided no evidence that he was ever treated for a psychotic illness at any time relevant to this matter. The [redacted] psychiatrist assertion that Appellant's medical documentation establishes only a consistent diagnosis of alcohol dependence is correct. It appears that Appellants mental health problems have been secondary to his long history of chronic alcoholism. There is no evidence to establish that Appellant would continue to have a qualifying diagnosis of Psychosis-NOS if he stopped drinking alcohol. According to a Consultation report from Lakeland Regional Health System, on [redacted] Appellant was admitted to the psychiatric floor of the hospital, due to Dementia secondary to alcoholism and alcoholic encephalopathy; and he had fallen several times. Further, prior to being admitted to an acute-care hospital, Appellant underwent an OBRA PASARR assessment. This assessment revealed that Appellant's primary diagnosis is related to a long history of alcohol dependence as opposed to active mood issues. OBRA determined that: it was not appropriate for Appellant to be placed in a nursing home; his needs would best be met in a facility that specializes in traumatic brain injuries; and depending on Appellant's cognition, it was recommended that he continue substance abuse treatment and close monitoring for the emergence of mood symptoms.

In conclusion, Appellant failed to establish by a preponderance of credible evidence that he met the eligibility criteria for the MDCH/CMHSP Managed Specialty Supports and Services Contract Medicaid service eligibility requirements for Medicaid-covered specialized mental health services. Appellant established a primary diagnosis which is not recognized as a severe and persistent mental illness for Medicaid beneficiaries who are requesting CMH services. Therefore, the denial of services is upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department/[redacted] properly determined that Appellant did not meet the MDCH/CMHSP Managed Specialty Supports and Services Contract Medicaid service eligibility requirements for Medicaid-covered specialized mental health services.

IT IS THEREFORE ORDERED that:

The Department's/WCHO's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/8/2009

***** NOTICE *****

SOAHR 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 SOAHR 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.