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:

[redacted]

Appellant
_____/

Docket No. 2009-19273 CMH
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a telephonic hearing was held on [redacted]. [redacted]) appeared and testified on her own behalf. Also appearing as a witness for the Appellant was [redacted].

[redacted], appeared on behalf of the [redacted]-hereafter, 'Department'), an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded mental health specialty supports and services.

ISSUE

Does the Appellant meet continuing service eligibility requirements as an adult with a serious mental illness?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is an adult Medicaid beneficiary, who, since [redacted], has been receiving outpatient therapy and medication review services through the auspices of [redacted]. She has a history of depression. *(Exhibit 1; page 2)*

2. In [redacted], the [redacted] Utilization Management (UM) Department completed a review and determined the documentation provided did not reveal a medical necessity for continued outpatient therapy. UM requested either that additional documentation be provided showing a medical need for continued outpatient therapy or that the Appellant be transitioned to a Medicare provider, as she also has Medicare coverage.

3. On [redacted] a second review was completed. UM determined that the Appellant did not meet medical necessity criteria for continued outpatient therapy. Therefore, on [redacted], the Appellant was issued an Advance Notice of termination for the services of outpatient therapy and medication reviews through [redacted], a [redacted]-contracted provider. UM determined the Appellant could continue with outpatient therapy services through her Medicare coverage provider. *(Exhibit 1; page 8)*

4. The documentation available for review suggests the Appellant has a diagnosis of depression, but that this is not verified by a psychiatrist or other mental health professional. The Appellant does not suffer from a substantial impairment in the ability to perform activities of daily living such that self-sufficiency is markedly reduced (e.g., personal hygiene and self-care, self-direction, learning, recreation, social transactions or interpersonal relationships). *(Exhibit 1; page 2)*

5. For the audit period [redacted] the Appellant was seen for six outpatient therapy sessions, with an equal number of no-shows. There is a long history of chronic absences and no-shows from the time of [redacted] intake. The Appellant reported that her medications were working well for her and that overall psychiatric symptoms were not restricting her life. She continues to struggle with financial issues and estrangement from her children. She also continues to struggle with memories of past abuse inflicted upon her by family and ex-spouses. *(Exhibit 1; pages 4, 18)*

6. On [redacted], the Appellant filed her Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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…

As applied to adult beneficiaries, NBHS utilizes the criteria outlined in the *MDCH/CMHSP Medicaid Managed Specialty Supports and Services Contract 1915(b)/(c) Waiver Program FY 03-04: Attachment P 3.3.1-and Attachment P 3.3.2., 10/01/02 revision;* (Contract).

Severe and Persistent Mental Illness is defined in the Contract as:

> 1. Diagnoses 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. Degree of Disability-Substantial disability/ functional impairment in three or 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, symptomatology, 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.

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfies that burden must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

Does the Appellant possess a qualifying mental health diagnosis?

No. The Appellant has a history of depression, but the medical documentation provided does not contain a definitive qualifying mental health diagnosis of a psychiatrist, psychologist, or other health care provider qualified to render the same.

Has the Appellant's history of depression resulted in substantial disability/functional impairment in three or more primary aspects of daily living such that self-sufficiency is markedly reduced?

No. The record is devoid of evidence to suggest the Appellant's depression results in marked reduction of self-sufficiency. The evidence suggests the Appellant continues to suffer from episodic depression related to financial difficulties and memories of abuse at the hands of ex-husbands and other family relations.

The Appellant testified at hearing regarding the abuse she has suffered in the past, and about the loss associated with estrangement from her children. However, she otherwise failed to produce a preponderance of evidence to suggest that she meets continued criterion for Medicaid-funded mental health specialty supports and services.

DECISION AND ORDER

Based upon a preponderance of the objective medical evidence presented, I decide that [redacted] has properly concluded the Appellant no longer satisfies the *MDCH/CMHSP Medicaid Managed Specialty Supports and Services Contract 1915(b)(c) Waiver Program FY 03-04* service eligibility requirements for a person with a severe and persistent mental illness.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
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 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.