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. 2009-19981 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 [redacted]. [redacted] represented herself. [redacted], represented [redacted] (CMHS).

ISSUE

Did [redacted] properly terminate Supports Coordination and Psychiatric Services for 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 Medicaid beneficiary.

2. [redacted] is a pre-paid Inpatient Health Plan (PIHP) and contractor of the Michigan Department of Community Health (MDCH).

3. The Appellant is diagnosed with a serious mental illness and lives independently in the community.

4. The Appellant has been authorized to receive supports coordination services and psychiatric services through CMHS.

5. The Appellant's most recent psychiatric evaluation was in [redacted]. The report generated indicates an Axis I diagnosis of bi-polar disorder, type II, depressed-296.89, history of polysubstance dependence, in full remission-304.80, Axis II borderline personality disorder-301.83. She had a GAF of 64.

6. The Appellant was authorized for psychiatric treatment services and case management services. The last case management appointment the Appellant kept was [redacted].

7. The Appellant has not had an IPOS updated since [redacted]. The Appellant has canceled or not shown up for any appointments for case management or psychiatric services 8 times since [redacted]

8. On [redacted] CMHS sent the Appellant an Advance Negative Action Notice indicating her services would be terminated based on her lack of utilization of services.

9. The Appellant requested a formal, Administrative Hearing on or about [redacted].

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 and Support program waiver in conjunction with a section 1915(c) HSW. [redacted] contracts with the Michigan Department of Community Health to provide services under the HSW.

The Appellant is entitled to Medicaid funded services through CMHS 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*. Case management is a Medicaid covered service. (See Medicaid Provider Manual, Mental Health and Substance Abuse Section, Section 13) The issue in this case is whether continued authorization of case management and psychiatric services are medically necessary for Appellant.

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 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).
>
> *Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 03-04, Section 3.2, page 27.*

In this case the Department's witnesses testified their actions came as a result of a utilization review. The Appellant had called to reschedule and/or simply failed to show up for several appointments with [redacted] and her supports coordinator. In [redacted], she called to re-schedule the meeting with her case manager. The meeting was to address the issue of her IPOS. It was re-scheduled at her request. Then she failed to attend the re-scheduled meeting. She had not attended a psychiatric appointment since early [redacted]. She did not have a valid IPOS and was avoiding the case management meeting wherein it was to be developed. In short, she was not using the services she was authorized to receive. The MHS witness presented evidence services are not medically necessary as evidenced by her lack of utilization of them.

The Appellant asserted she had been depressed, it had been a hard winter and she had car trouble. She was asked if she had trouble with her sobriety. She said she had. She admitted she was not using the services she had been authorized to use. She did not contest the evidence of all the missed appointments. She presented no evidence of medical necessity for the services.

This ALJ finds the Department provided sufficient credible evidence that Appellant had not utilized the services authorized thus evidencing a lack of medical necessity for the Appellant to have the authorization for them. Because the case management and psychiatric services authorized are no longer medically necessary, CMHS properly terminated them.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's action in terminating the services authorized for the Appellant was proper as not medically necessary.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 7/13/2009

***** 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.