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. 2009-23280 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]. The Appellant appeared without representation. She had no witnesses. [redacted], hearings coordinator, represented the Department. Her witness was [redacted], coordinator of utilization management.

ISSUE

Did the Department properly terminate the Appellant's Outpatient Therapy and Medication Reviews?

FINDINGS OF FACT

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

1. At the time of hearing the Appellant is a [redacted], Medicaid/Medicare beneficiary. Appellant's Exhibit #1.

2. The Appellant is afflicted with Organic Affective Syndrome, R/O Schizophrenia, Cocaine and Ethanol dependence with auditory hallucinations. Department's Exhibit A, p. 9.

3. The Appellant is compliant with her medications and demonstrated "adequate symptom abatement' including long standing sobriety. Department's Exhibit A, pp. 12, 13 and *See* Testimony of [redacted].

4. Following a record review the Department determined that the Appellant no longer met the medical necessity for continued treatment having achieved her goals in her individual plan of service (IPOS). Department's Exhibit A, pp. 2-13.

5. The Appellant, as of [redacted], no longer demonstrated a serious mental illness. Department's Exhibit A, p. 9.

6. The Appellant was advised of the Department's action on [redacted]. Her further appeal rights were contained therein. The Department advised the Appellant of her effective action date as [redacted]. Department's Exhibit A, pp. 16-19.

7. The instant request for hearing was received by the State Office of Administrative Hearings and Rules for the Department of Community Health on [redacted]. 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

> 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) Habilitation Supports Waiver (HSW).

The [redacted] contracts with the Michigan Department of Community Health to provide services under the Medicaid Managed Specialty Services and Support program waiver. Services are provided by [redacted] pursuant to its contract obligations with the PIHP/Department.

Medicaid beneficiaries are entitled to services through CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH/CMHSP Medicaid Managed Specialty Supports and Services Contract 1915 (b)(c) Waiver Program FY 03-04.
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.

The Medicaid Provider Manual describes the medical necessity criteria which the Appellant is required to maintain for continued eligibility:

* * *

MEDICAL NECESSITY CRITERIA

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

*** * ***

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.

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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 PIHP 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.

MPM, Mental Health, §§2.5 – 2.5.D, April 1, 2009, pages 12, 13, 14.

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The Department witness, [redacted], testified that the Appellant's OT services and medication management were no longer medically necessary. The Appellant was deemed to have achieved her IPOS goals. She was stable, compliant and sober. She further indicated that the Appellant no longer demonstrated the severity of symptoms which would justify continued specialized services.

The Appellant's own testimony bolstered the Department's conclusion that the Appellant was compliant – having seen her therapist last month and having scheduled another appointment for Saturday.

On review, it is apparent that the Appellant has achieved the goals established under her IPOS. The Department's decision to terminate the Appellant's OT and medication review was appropriate 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 terminated the Appellant's services for lack of medical necessity.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 7/31/2009

***** 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.