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. 2009-28239 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] (Appellant) appeared and testified on his own behalf. [redacted] for [redacted]), represented the Department's agent, [redacted]. [redacted], testified as a witness for the Department.

ISSUE

Did the Department [redacted] properly determine that Appellant did not meet the 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] beneficiary who is enrolled in a Medicaid Health Plan.

2. [redacted] is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the the [redacted]

3. [redacted] is an affiliate of [redacted] and provides Medicaid covered services to individuals in [redacted].

4. Appellant applied for Medicaid-covered specialized mental health services. (Exhibit 1)

5. On [redacted] completed an Emergency Screening of Appellant for Community Mental Health (CMH) services which determined that Appellant had an Axis I diagnosis of an Adjustment Disorder with mixed anxiety and depression 309.28; and Appellant was given a secondary diagnosis of Nondependent Alcohol Abuse-episodic drinking behavior. (Exhibit 1, p. 12)

6. On [redacted] completed an Access Screening of Appellant for Community Mental Health (CMH) services which determined that Appellant had an Axis I diagnosis of an Adjustment Disorder with mixed disturbed emotions & conduct. (Exhibit 1, p. 21)

7. Appellant was determined to be experiencing or demonstrating mild or moderate psychiatric symptoms or signs of subjective distress or mildly disturbed behavior with mild or moderate limitations or impairments that affect his daily living. (Exhibit 1, pp. 16-22)

8. On [redacted] completed an Access Screening of Appellant for Community Mental Health (CMH) services which determined that Appellant had an Axis I diagnosis of Relational Problem NOS V62.81. (Exhibit 1, p. 30)

9. On June 11, 2009, a [redacted] Second Opinion Clinical Screening was completed and revealed that Appellant had an Axis I diagnosis of a Mood Disorder (296.9) and Alcohol Abuse (305.00); and it was determined that Appellant was not limited in the area of Personal Hygiene/Self-Care, he had mild limitations in his ability to do his activities of daily living, and he was moderately limited in the areas of self-direction, learning & recreation, and social/interpersonal relationships. (Exhibit 1, pp. 33-39)

10. Appellant received notice that his request for CMH services was denied.

11. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for hearing, protesting the denial of CMH services.

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 Appellant sought Medicaid covered mental health services through [redacted]. Appellant was screened several times for CMH services, and each time it was determined that he did not meet the eligibility criteria. The only issue to be resolved by this Administrative Law Judge is whether the Department's agent properly determined that Appellant did not meet the eligibility criteria for Medicaid-covered specialized mental health services.

1.6 BENEFICIARY ELIGIBILITY

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:

- The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or

temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.

- The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.

In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:

- The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).

- The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.

- The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year.

> (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.
>
> *Medicaid Provider Manual, Mental Health/Substance Abuse, Section, effective April 1, 2009*

Appellant was diagnosed with an Adjustment Disorder, Alcohol Abuse, Mood Disorder, and Relational Problem. Appellant was determined to be experiencing or demonstrating mild or moderate psychiatric symptoms or signs of subjective distress or mildly disturbed behavior with mild or moderate limitations or impairments that affect his daily living. Appellant failed to provide any evidence to establish that he is currently or has been mentally ill or emotionally disturbed, seriously, with a substantial impairment in his ability to perform daily living activities. In addition, Appellant failed to establish that he has a current or recent serous condition or was mentally impaired, seriously, in the past. Further, there is no evidence on the record to establish that Appellant has been treated by his Medicaid Health Plan (MHP) for his mild or moderate psychiatric symptoms and limited functional impairments and has exhausted the 20-visit maximum for the calendar year.

In conclusion, Appellant failed to establish by a preponderance of credible evidence that he met the eligibility criteria for Medicaid-covered specialized mental health services. Therefore, the denial of services is upheld. It is recommended that Appellant seek substance abuse treatment, and mental health treatment through his MHP.

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 eligibility requirements for Medicaid-covered specialized mental health services.

IT IS THEREFORE ORDERED that:

The Department's [redacted] decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 10/7/2009

***** 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.