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. 2009-29648 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 on behalf of her daughter, [redacted]).

[redacted], Assistant Corporation Counsel, appeared on behalf of the [redacted] Community Mental Health Services Provider ([redacted]-hereafter, 'Department'), an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded specialty mental health supports and services. Also appearing as a witness for the Department was [redacted], Access Services Manager.

ISSUE

For purposes of transitioning the Appellant to Medicaid Health Plan-covered mental health services, has the Department properly determined that 2 units of treatment planning, 3 units of medication management, and 9 units of psychotherapy is medically necessary to meet the Appellant's current specialty mental health needs for the period [redacted] through [redacted]?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid recipient enrolled in a Medicaid Health Plan and in the MIChild waiver program. *(Exhibit 1; p. 1)*

2. The Appellant has appealed the [redacted], reduction and/or denial of payment for outpatient mental health services through [redacted] from [redacted] to [redacted], at [redacted], an outpatient clinic under contract to [redacted]. [redacted] requested a six-month authorization of services (3 units of treatment planning, 6 units of medication review, and 18 units of psychotherapy). For purposes of transitioning the Appellant to her Medicaid Health Plan-covered mental health services, [redacted] authorized a shortened and reduced service package, to include 2 units of treatment planning, 3 units of medication management, and 9 units of psychotherapy. The authorization is reflected in the Adequate Action Notice dated [redacted]. *(Exhibit 1; Attachment A; p. 4)*

3. The Appellant's mental status, as reflected in her [redacted], Annual/Assessment Update, is agitated, with labile effect and loose thought, but intact memory, judgment and insight. *(Exhibit 1; Attachment D; p. 16)* The assessment further reflects no current homicidal/suicidal thoughts, urges, plans or behaviors; no history of such behavior, and no history of violent or assaultive behavior. She has also had no psychiatric or substance abuse hospital admissions within the past year. The *Integrated Summary* indicated that the Appellant presented with anxiety, depression, focus and concentration problems, and poor organizational skills, all of which have shown improvement. It reflects that her ADHD symptoms have been "…somewhat stabilized". *(Exhibit 1; Attachment D; pp. 18-19)*

4. The Appellant's Annual Plan of Service contains goals that include the Appellant's desire to "…pay attention, be happy, do her homework with confidence, not to say she cannot do something before trying, drawing, rollerblading, swimming, painting, fashion and soccer. *(Exhibit 1; Attachment E; p. 29)* Patient medication reviews reflect that the Appellant is prescribed Straterra, that she is "stable and improving", and that she is making "good" progress toward meeting the goals articulated in her plan of service. *(Exhibit 1; Attachment G; pp. 38-50)*

5. [redacted], [redacted] Notes reflect the Appellant was able to verbalize the causes of her anxiety and depression, and was able to articulate her worries and anxiety towards her mother. She also appeared less distracted and more capable of paying attention. The notes also appear to reflect the Appellant experiences relational problems with her step-father, but also appeared capable of understanding how to cope with those problems. She also appeared less hyperactive and denies suicidal ideation. *(Exhibit 1; Attachment H; pp. 77-83)*

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…

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 and Supports Waiver (HSW).

[redacted], a Prepaid Inpatient Health Plan (PIHP), contracts with the Michigan Department of Community Health to provide 1915(b) mental health services. The PIHP's contract with the Department requires that all services paid for with Medicaid funds must be medically necessary. [redacted]s denial of service hours requested by the Appellant is based upon its determination that the approved amount is sufficient to meet the Appellant's mental health needs, as of [redacted].

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
>
> 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.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. 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.
Version

Medicaid Provider Manual; Mental Health/Substance Abuse; Version Date: October 1, 200; Pages 12 - 14

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).

During the hearing, [redacted] asserted that the Appellant no longer met eligibility criteria for specialty mental health services, and that the reduction is designed to transition the Appellant out of specialty mental health services to Medicaid-covered Medicaid Health Plan services. However, the written Adequate Action Notice authorizes reduced services, and does not terminate them entirely. Thus, my decision here adjudicates only whether the reduction in services at this point, based on the evidence presented, is appropriate.

7. [redacted] witnesses credibly testified, and the medical documentation reflects,

> that, aside from relational problems with her step-father, the Appellant's signs and symptoms have stabilized on medication. According to progress notes, the Appellant shows good progress, thereby militating against a finding that her functional abilities are markedly impaired with regard to activities of daily living. In fact, the evidence establishes the Appellant is doing well in school, and that, aside from occasional setbacks due to relationship issues, is steadily improving. *(Exhibit 1; Attachment H; pp. 77-83)*

The Appellant's mother testified only that the Appellant's mental health will deteriorate if she is forced to treat with a different psychiatrist. She claims the Appellant's current psychiatrist is also of [redacted] descent and that the Appellant is therefore comfortable due to similar cultural beliefs. Although this is a valid concern, it is not currently a relevant factor in determining services from a Medicaid policy perspective. The Appellant's mother otherwise offered no challenge to the [redacted] position in this regard.

DECISION AND ORDER

Based upon a preponderance of the objective medical evidence presented, I decide that [redacted] has properly provided an appropriate amount, scope and duration of Medicaid-covered specialty mental heath services, as articulated in its [redacted] notice.

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: 10/8/2009

***** 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.