STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted],
Appellant

_____/

Docket No. 2009-30284 CMH
Case No. [redacted]
Load [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], appeared on behalf of the Appellant. [redacted], interpreted for Appellant's mother. Also in attendance was Appellant who spoke on his own behalf.

[redacted] (CMH), represented the Department. [redacted], appeared as a witness for the Department.

ISSUE

Did CMH properly deny authorization for treatment planning, medication review and therapy services for 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 [redacted] Medicaid beneficiary (DOB [redacted]).

2. The Appellant is enrolled in a Medicaid Health Plan, [redacted]. (Attachment B, page 9).

3. [redacted] is a CMHSP.

4. Appellant has been receiving services from CMH since at least [redacted]. (Attachment C). Most recently Appellant has been receiving CMH services

through its [redacted] contractor. (Attachment G).

5. Appellant's Axis I diagnosis is Attention Deficit Hyperactivity Disorder (ADHD). (Attachment D).

6. In Appellant's [redacted], medication reviews his CMH psychiatrist reported he was "stable and improving." (Attachment E, p. 41, 42 and 43).

7. The Appellant is being prescribed the medication Metadate by the CMH psychiatrist. (Attachment E). The Appellant's medication has not changed since [redacted]. (Attachment E).

8. In [redacted] CMH and Appellant completed a pre-meeting person-centered plan input assessment. As a result of the input assessment the CMH Access Center denied authorization for continued CMH services. It concluded the Appellant was not eligible for CMH services because the Appellant's condition had improved so that he could receive his services through his MHP. (Exhibit C).

9. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating that his request for treatment planning, medication review and therapy services was denied. (Exhibit A).

10. The Appellant's request for hearing was received on [redacted]. (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 waiver. [redacted] contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH 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 *MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1* and Attachment 3.1.1, Section III(a) Access Standards-*10/1/08, page 4,* directs a CMH to the Department's Medicaid Provider Manual for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6 makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs 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.	□ 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 and Substance Abuse, Beneficiary Eligibility Section, July 1, 2009, page 3.

CMH Access Center witness [redacted] testified that CMH utilized *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6, July 1, 2009, page* 3 to determine the Appellant did not meet the eligibility for specialized mental health services provided through the CMH. In particular, CMH [redacted] testified the Appellant fell into the category of MHP responsibility. The specific language Medicaid Provider Manual Section 1.6 language CMH relied on is underlined directly above and its arguments are individually listed below.

Mild and moderate symptoms -

The CMH does not dispute that Appellant has ADHD. Rather, the CMH position is that the Appellant is not eligible for CMH Medicaid services because his mild and moderate symptoms can be managed by his MHP. CMH Access Center witness [redacted] testified that she personally reviewed Appellant's records. Looking at the Input for Person-Centered Plan [redacted] testified that Appellant's records showed he was not seriously emotionally disturbed and his mental health services could be provided through the twenty visits offered by his health plan (Exhibit C).

Stable –

CMH Access Center witness [redacted] testified she personally reviewed Appellant's records. [redacted] testified that Appellant's records showed that Appellant's illness was stable. (Attachment E, p. 42-46). An examination of the records from Appellant's [redacted], medication reviews demonstrate his CMH psychiatrist reported he was "stable and improving." (Attachment E, p. 41, 42 and 43). Based on the Appellant's documentation, CMH established that Appellant's condition was stable and could be managed within the services offered from his health plan.

No specialized supports and services –

[redacted] testified he personally reviewed Appellant's records. [redacted] testified that Appellant remained on the same medication and same quantity for [redacted]. [redacted] indicated that an individual who for [redacted] has had no changes in medication shows he is very stable on medications. Based on the Appellant's medical documentation, CMH determined that it was sufficient for the Appellant to receive medication reviews one time every three months and therefore could receive his medication reviews through the 20 mental health visits offered by his MHP. An examination of the medication record from [redacted] until time of appeal and combined with the CMH witness testimony, CMH established that Appellant needs ongoing routine medication management without specialized services and supports. (Exhibit E, p. 40).

The Appellant competently stated that in the past he was depressed and had thoughts of suicide, but since that time he has felt better and has not had thoughts of suicide.

Appellant's mother expressed concern that Appellant would have to switch his established CMH doctor and CMH therapist if provision of his mental health services was moved to the

MHP. CMH agreed during the hearing that it would authorize two months of CMH services to facilitate Appellant's transition to receiving mental health services from [redacted]

[redacted] provided credible evidence that the Appellant meets the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that he met the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the CMH.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

> The Appellant does not meet the Medicaid Provider Manual eligibility requirements for Managed Specialty Supports and Services provided through the MHP and not the CMH.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 10/16/2009

***** 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.