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. 2009-31318 CMH
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] was represented by [redacted].

[redacted] (hereinafter CMH or Department) represented the Department of Community Health's agent. [redacted] for the CMH was present as a witness.

ISSUE

Did [redacted] properly propose reduction and termination of individual therapy and medication management 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 diagnosed with a serious mental illness.

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

3. The Appellant has received specialty supports and services from the CMH for the last [redacted]. She has received medication management and therapy services.

4. The Appellant is taking anti-psychotic medication and anti-depressant medications. She resides with her family in the family residence.

5. The Appellant speaks limited English.

6. The Appellant has a history of psychiatric symptoms including psychosis and in–patient psychiatric hospital admissions.

7. The Appellant has not had recent in-patient psychiatric hospitalizations. She reports no recent psychotic episodes.

8. The client's most recent [redacted] clinical documentation includes reports of occasional thought of suicide. No report of a plan to harm herself is included in the clinical documentation. No reports of hallucinations or delusions is made in the most recent clinical documentation.

9. The most recent annual assessment update, [redacted], indicates the Appellant's mental status. It states her appearance is well groomed, speech and thought content are normal. Her motor activity is agitated, affect is labile, her mood is anxious, thought process is loose, judgment and insight are both intact. She is fully oriented.

10. The Appellant attends her bi-weekly therapy sessions regularly and attends her medication management appointments, despite having re-scheduled on occasion.

11. The most recent IPOS is dated [redacted] and was scheduled for completion [redacted]. The plan included 12 units per month of individual therapy, 1 psychiatric evaluation for the year and 1 unit per month of medication management.

12. A request for authorization of services made on or about July 15, 2009, included 18 units per month therapy, 1 unit of assessment, 3 units of treatment planning and 6 units of medication review.

13. [redacted] proposed termination of services [redacted], with a reduced authorization proposed to be effective upon issuance of the Notice, dated [redacted]. The proposed authorization was for 0 units of assessments, 1 unit of treatment planning, 4 units of therapy and 2 units of medication review. The proposed reduction was for immediate implementation and termination of all services was to be effective [redacted].

14. The Appellant contests both the reduction and termination of her therapy and medication services.

15. [redacted] cites improvement in the Appellant's condition as evidence of lack of serious mental illness at this time and reason

for termination of services through the CMH.

16. [redacted] proposes to have the mental health services required by the Appellant be provided by her Medicaid Managed Health Plan, which limits therapy services to 20 visits per year.

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:

> **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.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. 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:	**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 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 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 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.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP.

The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when 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. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual’s needs, and meet the standards herein. A person-

> centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2009.*

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*. Individual or family therapy is a Medicaid covered service. (See Medicaid Provider Manual, Mental Health and Substance Abuse Section, Section 13) The CMH asserts continued authorization of therapy services is not medically necessary for Appellant.

The Medicaid Provider Manual defines terms in the Mental Health/Substance Abuse section dated July 1, 2009. It defines medical necessity as follows:

> 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. Medical necessity of a service shall be documented in the individual plan of services.
>
> Medicaid Provider Manual
> Mental Health /Substance Abuse
> Version date July 1, 2009.

Page 18 of the section addresses medical necessity further:

> **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.

Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: October 1, 2009

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.

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SECTION 3 – COVERED SERVICES

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the

additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended.

3.8 FAMILY THERAPY

Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker.

3.11 INDIVIDUAL/GROUP THERAPY

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.

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The reduction and termination proposed by the CMH is not supported by the Appellant's treating therapist, who requested authorization for additional units of therapy, assessment

and treatment planning. The therapy case notes indicate a worsening of symptoms beginning in [redacted]. The symptoms include suicidal thoughts, although no plan. Inability to sleep is reported consistently, as are feelings of increased depression, racing thoughts, feelings of worthlessness. Her coping ability was being challenged by family stressors according to documentation submitted. Additionally, the most recent formal assessment of her mental state did not indicate she was functioning at a normal level in many areas. She has agitated motor activity, her affect is labile, mood anxious and thought process is loose. While these indications would not preclude a termination of service in every circumstance for every beneficiary, in this case there is insufficient evidence to support a finding that continued specialty treatment through the CMH is not medically necessary.

The Appellant is currently experiencing an increase in symptoms, despite not reporting psychotic or delusional symptoms. She does have a history significant for psychotic features, requires medication to control those symptoms and has had more than one psychiatric in-patient admission. Furthermore, she does not speak English fluently. Her cultural status is of relevance according to the Policy. Sudden discontinuation of her treatment for someone who cannot speak the prevailing language does not appear appropriate in this circumstance, when she is experiencing an increase in symptoms.

This ALJ did consider the evidence presented by the CMH including treatment records. It is noted she has experienced a decrease in psychotic symptoms and has had success with her medication. This is insufficient evidence the therapy services requested are not medically necessary. There was testimony that was the conclusion reached, however, the specific evidence relied on to reach that conclusion was too sparse for this ALJ to agree. A mere lack of psychotic symptoms is an insufficient basis for the termination of services given the Appellant's history and present functional status. Her functional status is of primary concern according to the policy contained in the Medicaid Provider Manual. The Appellant's functional status appears to be at risk of decreasing at the time the termination was proposed. Additionally, the Medicaid Provider Manual states the "critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary." There is no evidence in the record to support a finding that a sudden reduction and termination of services is the best treatment path for this beneficiary. Nor is there evidence of any contact with the Appellant's MHP for the purpose of coordinating a transition or treatment plan.

The Policy states "the mental health conditions listed in the table are intended as a general guide for PIHPs and MHPs in coverage determination decisions. They do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. Critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary." This ALJ saw no evidence consideration was given as to the best treatment path for this beneficiary, nor evidence of collaboration between the PIHP and the MHP.

This ALJ finds the authorization requested by the Appellant's treating therapist is shown to be medically necessary for the Appellant at this time. It is supported by clinical documentation,

designed to assist the Appellant maintain a sufficient level of functioning in order to achieve goals as stated in her IPOS. It is consistent with the Appellant's IPOS, responsive to her particular needs as part of a multi-cultural population and furnished in a culturally relevant manner; and sufficient in amount, scope and duration of the service(s) to reasonably achieve its purpose.

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 proposing termination of therapy and medication management services was improper.

IT IS THEREFORE ORDERED that:

[redacted] decision is REVERSED. The PIHP is hereby ordered to provide services as requested by the authorization request from the Appellant's treating therapist in the [redacted], request for authorization.

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

cc: [redacted]

Date Mailed: 10/15/2009

***** 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.