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

Appellant
______________________/

Docket No. 2009-36380 CMH
Case No.

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 . (CMH), was present on behalf of the Department of Community Health. , was also present. was present on behalf of the CMH. , was also present on behalf of the Department.

was present and represented himself at hearing.

ISSUE

Did CMH properly terminate authorization for medication review and case 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 dually eligible Medicare/Medicaid beneficiary. (uncontested)

2. is a CMHSP.

3. The Appellant has been receiving services from CMH for . He had an intake .

4. The Appellant was diagnosed with bi-polar disorder and alcohol abuse in

remission following evaluation. (uncontested)

5. The Appellant was authorized for case management and medication review services following intake in [redacted].

6. The Appellant is prescribed Abilify and has demonstrated improvement in signs and symptoms since his [redacted] intake assessment. (testimony from CMH)

7. In the [redacted], psychosocial assessment the Appellant was considered improved and stable. No need for case management services was found. (testimony from CMH)

8. The Appellant lives with his wife in his own home. He operates a motor vehicle. (uncontested)

9. The Appellant has access to and knows how to access medical services. The Appellant has financial resources, in the form of disability payments, as does his wife. (uncontested)

10. The Appellant has access to and knows how to use services and programs offered by the Department of Human Services. (uncontested)

11. The Appellant expressed a desire to re-locate to [redacted] due to his experiences socially in the community of [redacted]. (uncontested)

12. The Appellant contacted a real estate agent for the purpose of attempting to sell his home to facilitate his desire to re-locate. (uncontested)

13. The most recent IPOS for the Appellant was completed in [redacted]. It addressed discharge plans and stated the Appellant would most likely be ready for discharge from CMH services within the next 12 months. It further indicated the next review would take place in 3 months.

14. In [redacted], the Appellant was sent a Negative Action Notice stating services were being terminated due to his request. The Appellant sent a request for hearing, received [redacted].

15. On [redacted], the Appellant was sent a second Notice. The second Notice indicated services for both case management and medication review, would terminate due to lack of medical necessity.

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*
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> 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 CMH notified the Appellant his case management and medication management services would be terminated. He was advised his primary care physician or a Medicare provider could provide medication management services and that case management services were not medically necessary. The Appellant objects, citing a need for someone to talk to. He did not dispute the assertion that medication management services could otherwise be provided. He is entitled to Medicaid funded services through CMH if the following conditions are met:

1. They meet the service eligibility requirements per the MDCH Medicaid Provider Manual guidelines.

2. The service in issue is a Medicaid covered service, i.e. State Medicaid Plan or waiver program service, and

3. The service is medically necessary.

Case management is a Medicaid covered service if medically necessary. One issue in this case is whether continued authorization of case management services is 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 services I medically (clinically) appropriate, necessary to meet needs, consistent wit 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.
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> Medicaid Provider Manual
> Mental Health /Substance Abuse
> Version date July 1, 2009, page 5.

> **SECTION 13 – TARGETED CASE MANAGEMENT**
> Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive,

coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS
Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED
The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and

desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.

Documentation The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs.

The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than

annually to review progress toward goals and objectives and to assess beneficiary satisfaction.

Monitoring The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services. Targeted case management may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: July 1, 2009 Pages 67-68
Michigan Department of Community Health

In this case the CMH provided evidence the Appellant does not require case management services. The uncontested evidence includes the fact that the Appellant resides with his wife, thus has natural supports. He lives in his own home and operates a vehicle, thus has no need for services connecting him to other resources due to current crises. He has medical coverage in the form of Medicare and Medicaid and knows how to access providers.

The Appellant functions independently in making his daily decisions, ordering his day and performing ADL's and IADL's. He is not exhibiting signs or symptoms of a serious mental illness that interferes with his day to day functioning. He is able to identify his priorities, express them and take action to accomplish them, according to the evidence of record.

The Appellant's evidence of need was primarily identification of anger management issues and a need for someone to talk to. Also in evidence is the fact of delinquent bill paying and substandard care taking of his home environment. It has been suggested to the Appellant that he use payee services but he has not availed himself of that service. The need to have someone to talk to is not properly addressed by direct case management services. Nor is anger management therapy part of case management services. Rather, the Appellant can access his medical benefits to participate in counseling, should he desire to do so, to address anger issues or conflicts. He can and does access socialization opportunities in the community. He does not require a case manager to arrange this for him. Uncontested evidence in the record demonstrates he is quite capable of pursuing his wants and needs. He identified his desire to reside in [redacted], because he was enjoying a social outlet he participated in the community. He contacted a real estate agent in order to facilitate a re-location to [redacted]. This is good evidence the Appellant is capable of arranging what he wants to arrange, despite his claim of need for service.

The CMH also sent Notice that medication management services would be terminated due to lack of medical necessity. The CMH presented evidence the Appellant can have his medication prescribed by his primary care physician. He is stable and improved since intake back in [redacted]. He is compliant with medication. There was no evidence to contest these material facts. No evidence of medical need for medication management services was presented by the Appellant.

[redacted] provided credible evidence that there is no medically necessary need for case management services or medication management services for the Appellant. 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 CMH.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

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

cc:

Date Mailed 12/10/2009

***** 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.