STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF

Docket No. 2010-14437 CMH
Case No. 89010315

[redacted],
Appellant

_____/

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] represented the Department's agent [redacted] or CMH). [redacted] appeared as a witness for the Department/CMH.

ISSUE

Did the CMH properly suspend the Appellant's physical therapy services?

STIPULATED FACTS

There are no disputed facts in the case. The following is a listing of material stipulated facts:

1. The Appellant is an [redacted] year-old Medicaid beneficiary.
2. [redacted] is a Community Mental Health Services Program (CMH).
3. [redacted] is responsible for providing Medicaid-covered services to eligible recipients in its service area.
4. The Appellant is enrolled in CMH. (Exhibit A, pages 1 and 4).
5. The Appellant's current Person-Centered Plan (PCP or IPOS) effective [redacted], authorized physical therapy services through CMH. (Exhibit A, pages 13 and 14).
6. The Appellant had been receiving physical therapy services from CMH prior to [redacted]. (Exhibit A, pages 28-36).

7. In or around [redacted], the CMH stopped providing physical therapy services.

8. On [redacted], CMH sent the Appellant written notice that her physical therapy services would be suspended. (Exhibit 3). The suspension notice incorrectly stated "eligibility" as the reason for suspension of physical therapy services. (Exhibit 3). Appellant's physical therapy services were suspended because the CMH did not have sufficient physical therapists under contract to provide physical therapy to its clients. (Exhibit 4).

9. There are over six physical therapy practices and over one dozen physical therapists in Appellant's/CMH's area. (Exhibit A, p 37-38).

10. The Appellant's request for hearing was received by this State Office of Administrative Hearings and Rules for the Department of Community Health on [redacted] (Exhibit 2).

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. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

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*. Physical therapy is a Medicaid covered service available through CMH. See *Medicaid Provider Manual, Mental Health and Substance Abuse Section, Section 3.19, January 1, 2010, p. 20*).

Medicaid Provider Manual, *Mental Health and Substance Abuse Chapter, January 1, 2010, p. 13,* defines medical necessity and the criteria used to determine medical necessity for a Medicaid-covered service:

> **2.5.B Determination Criteria**
>
> The determination of a medically necessary support, service or treatment must be:
>
> … For persons with…developmental disabilities, based on person-centered planning…

The parties stipulated that Appellant's IPOS authorized CMH to provide physical therapy services to Appellant. The CMH further stipulated that the reason for suspension of Appellant's physical therapy was CMH's failure to maintain an adequate provider network of physical therapy providers.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 09, Part II, *Section* 6.4*, page 42,* is the section of the contract between [redacted] CMH and the Department (MDCH-CMH Contract) that addresses [redacted] obligation to maintain an adequate provider network of physical therapy providers:

> **Provider Network Services**
>
> The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract.
>
> In this regard, the PIHP agrees to:
>
> F. Notify MDCH within seven (7) days of any changes to the composition of the provider network organizations. PIHPs shall have procedures to address changes in its network that negatively affect access to care.
>
> Changes in provider network composition that MDCH determines to negatively affect recipient access to covered services may be grounds for sanctions. (Underline added.)

At the time of Appellant's [redacted] request for hearing [redacted] did not have an adequate provider network of physical therapy providers. As of the date of hearing in [redacted], the CMH [redacted] did not have an adequate provider network of physical therapy providers. The Appellant's father provided documentation that physical therapy services are available in the Appellant's area of [redacted]e, including more than six physical therapy practices and more than one dozen physical therapists in Appellant's/CMH's area. (Exhibit A, p 37-38). The CMH explained that the problem was not lack of physical therapists in the area, rather the failure of [redacted] to contract with providers of physical therapy services for CMH clients.

The federal regulation, MDCH policy and the MDCH-CMH Contract require that the medical necessary, Medicaid covered services identified in Appellant's IPOS, including physical therapy, must be provided. [redacted] failure to contract with providers of physical therapy services for CMH clients does not relieve [redacted] of its contractual obligations.

The undisputed evidence in this case demonstrates that [redacted] is not meeting its MDCH-CMH Contract obligations. [redacted] non-compliance with the MDCH-CMH Contract negatively affects Appellant's access to physical therapy services and is grounds for [redacted] to be subjected to sanctions by the Department.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH's suspension of the Appellant's physical therapy services was not proper and is not in compliance with the MDCH-CMH Contract.

IT IS THEREFORE ORDERED that:

- The [redacted] decision and action to suspend Appellant's physical therapy services is REVERSED.

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

cc: [redacted]

Date Mailed: 03/11/2010

***** 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.