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

Docket No. 2010-25697 CMH
Case No. [redacted]

[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], Appellant's father, appeared on behalf of the Appellant. [redacted], Appellant's mother was also in attendance.

[redacted], Assistant Corporation Counsel, Macomb County Community Mental Health Authority (CMH), represented the Department. [redacted], CMH Access Center Manager, appeared as a witness for the Department.

ISSUE

Did CMH properly deny authorization for 18 sessions within six (6) months of 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 at time of hearing (DOB [redacted]).

2. Macomb County CMH is a CMHSP.

3. Appellant has been receiving services from CMH since at least [redacted]. (Exhibit G). Petitioner's person-centered plan (PCP) authorized community living supports, respite and individual therapy. (Exhibit E).

4. Prior to [redacted], the Appellant was receiving CMH individual therapy services through its Macomb Family Services contractor. (Exhibit F, p 44).

5. Prior to [redacted], Appellant's Macomb Family Services therapist requested authorization for 18 individual therapy sessions for a period of six (6) months. (Exhibits A, B).

6. The CMH reviewed the request and the progress notes from Appellant's therapy sessions and requested further documentation from Appellant's Macomb Family Services therapist. Supporting documentation was not provided by Appellant's Macomb Family Services therapist. (Exhibit G).

7. As a result of not receiving supporting documentation the CMH Access Center denied authorization for 18 individual therapy sessions. CMH did approve three (3) sessions for the six (6) month period. (Exhibit A).

8. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating that her request for 18 individual therapy sessions for a period of six (6) months was denied. (Exhibit A).

9. The Appellant's request for hearing was received on [redacted]. (Exhibit C).

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. Macomb County CMH 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 Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

> **2.5.B. MEDICAL NECESSITY 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 personcentered 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2010, page 13.

The CMH does not dispute that Appellant may have therapy needs. Rather, CMH representative [redacted] stated that CMH is obligated to follow the Department's medical necessity criteria. CMH Access Center witness [redacted] pointed out that in documentation submitted it showed that Appellant's goal for therapy may have been met and she was more stable. CMH Access Center witness [redacted] testified that without having the progress records from Appellant's therapist, it was not possible to determine if there was a medical need and if so, how many sessions per month would meet Appellant's medical need. Looking at the progress notes [redacted] testified that Appellant's supports coordinator did finally reach Appellant's therapist who indicated she had not sent the requested because she was undergoing chemotherapy for cancer. (Exhibit G, p 52).

Appellant's father expressed concern that although Appellant was stable, she had just found out that one of the medications she took years ago could cause kidney problems. Appellant's father also said that Appellant was recently in contact with her biological family. Appellant's father brought a [redacted], note from Appellant's therapist and read the contents into the record.

The CMH responded that the short paragraph from Appellant's therapist only stated goals but never provided the "summary report" previously requested by CMH. Without the summary report of Appellant's progress in [redacted], the CMH stated that it was without sufficient information about whether all her [redacted], goals were met or to determine need for mental health services. (Exhibit A, and pages 8, 52 and 53).

Appellant's father stated that Appellant wanted to stay with her therapist even if she would have to see her less due to the therapist's chemo treatment.

The burden is on the Appellant to prove by a preponderance of evidence that individual therapy was medically necessary at a level of 18 sessions for six (6) months. Because Appellant's therapist had not provided the required evidence, the Appellant did not meet her burden.

DECISION AND ORDER

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

The CMH properly deny authorization for 18 sessions within six (6) months of therapy services for Appellant.

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: 6/11/2010

***** 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.