

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

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IN THE MATTER OF

██████████,
Appellant

_____ /

Docket No. 2010-49415 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 on ██████████. ██████████ appeared on behalf of the Appellant. Her witness was ██████████, behaviorist. Her translator was ██████████, attorney, represented the Department. Her witness was ██████████.

ISSUE

Did the Department properly deny occupational therapy services to 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. (Appellant's Exhibit #1)
2. He is lives at home with his parents and sister. He has limited speech. He is described as ambulatory, hyperactive and isolative, needing assistance with ADLs, but having been toilet trained at age one. His challenging behaviors include temper tantrums, distracting activity and wandering away. He is reported to like school.
3. The Appellant is identified as a person with autism. His school describes him as a person with moderate autism spectrum disorder. He attends a school program for persons with autism for half the day and then the ██████████

[REDACTED] program for the remaining half. (Department's Exhibit A, pre-hearing summary, p. 1)

4. The Department determined that any OT services were the responsibility of the Appellant's ISD and that services were no longer supported under the goals of the person centered plan. (See Testimony of [REDACTED])
5. The concerns underpinning the request for OT hours as developed in the goals of the [REDACTED] OT evaluation and the Person Centered Plan progress review of [REDACTED] reflect more of the parent's requests than evidence concerning why school services are inadequate. (See Testimony of [REDACTED] and Department's Exhibit pre-hearing summary p. 3)
6. The Appellant was notified of the denial of requested OT services by adequate action notice on [REDACTED]. (Department's Exhibit A, pp. 6-8)
7. The instant request for hearing was received by SOAHR on [REDACTED] (Appellant's 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

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...

Section 1915(c) of the Social Security Act provides:

The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded...

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 in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The Macomb County Community Mental Health SP contracts with the Michigan Department of Community Health to provide those services.

While it is axiomatic that Medicaid is the payer of last resort the CMH is the entry point for treatment of serious mental illness. The service criteria for this capitated provider are medical necessity. However, duplication of service is prohibited under the Medicaid Provider Manual:

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. (Emphasis supplied)

MPM, §3, Mental Health [] July 1, 2010, p. 15

In performing the terms of its contract with the Department, the CMHSP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

[] 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.

[] PIHP/CMHSP DECISIONS

Using criteria for medical necessity, a PIHP/CMHSP 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.

MPM, Mental Health [];
§2.5 et seq, July 1, 2010, pp. 11-13

The Department witness credibly explained that the requested hours of OT service were denied for two reasons; first, it is the responsibility of the Appellant's school system to provide the service and; second, the Appellant's person centered plan no longer supported this level of therapy – as his goals, in addition to narrowing over time, can now be achieved through normal parenting actions. See Department's Exhibit A at sub I, pp. 70-73

The Appellant's representative said that her son needs "more than 15 minutes of OT during autism school" and that she hoped he would receive the PT and OT he needs.

On review, the Appellant failed to preponderate his burden of proof that the requested OT services could be provided by the CMH [as opposed to the ISD] or that they continued to be medically necessary.

The Department's action was proper when made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied OT services.

[REDACTED]
Docket No. 2010-49415 CMH
Hearing Decision & Order

IT IS THEREFORE ORDERED that

The Department's decision is **AFFIRMED**.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 11/12/2010

***** 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.