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. 2010-54293 CMH

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 . , MD, appeared on behalf of the Appellant. Her witnesses was her spouse , personal assistant, and , TCI supports coordinator. , attorney, represented the Department. Her witness was manager Access Center.

ISSUE

Did the Department properly deny the Appellant's request to receive Occupational Therapy (OT)?

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 lives at home with his parents, siblings and great aunt. (Appellant's Exhibit #1)
3. He is identified as a person with autistic disorder, moderate MR, a hole in his heart, and seizure disorder. His physican parents further identify ADHD, fine motor weakness, and VSD. (Department's Exhibit A, p. 1 *and* Appellant's Exhibit #1, p. 2)

4. The Appellant has received active OT since [redacted]. An evaluation conducted on [redacted] reported good upper extremity range of motion and strength, but low muscle tone in his trunk. He has a weak pincer grip and difficulty manipulating small objects. His goals were listed as; improvement of fine motor coordination, improvement in attention to task, improvement is social settings learning self regulation techniques to reduce anxiety and aggressive behavior. (Department's Exhibit A, p. 2)

5. On [redacted], the Appellant requested 87 units of OT which was reviewed by the Department and denied for lack of medical necessity. (Department's Exhibit A, p. 5)

6. On [redacted] the Department sent the Appellant an adequate action notice advising him of the denial and his further appeal rights. (Department's Exhibit A, pp. 5- 7)

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 remains the entry point for treatment of serious mental illness. The service criteria for this capitated provider is medical necessity 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.

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[ ] 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, , testified that the requested hours of OT service were denied because there was no evidence to support the idea that OT was effective as a durable remedy for aggression or insomnia - accordingly it was not medically necessary under the MPM.

testified that evidence did not support an indication that the Appellant had enjoyed sustained improvement within a reasonable timeframe through the use of OT – as evidenced in the records submitted for hearing.

The Appellant's representative testified that the Appellant is not aware of his own strength and that he needs a maintenance environment in order to learn calming techniques to control aggression and insomnia - as well sensory issues.

On review, the Appellant failed to preponderate his burden of proof that OT was a medically necessary service or that the Department erred in denying the request. The Department's argument that the Appellant's treatment to date lacked durability was compelling – durability by common definition implies months if not years of relief or reliable service – something the Appellant's record simply fails to demonstrate.[1] [See Appellant's Exhibit #1 – throughout *and* Department's Exhibit A – throughout]

[1] Including recommended home programs from sensory testing conducted in *See* Appellant's Ex. 1 at page 12

However, the OT denial was only one component of the Appellant's CMH totality of service for this client. Since the Department remains the portal for psychiatric services in [redacted] presumably other evidence based treatment practices bode for discussion and review with the Appellant's guardians.

The Appellant failed to preponderate his burden of proof that the requested OT services could be provided by the CMH as an effective and medically necessary service.

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.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: ________________________

***** 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.