STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

[redacted]
Appellant
_____/

Docket No. 2011-13288 CMH
Case No. 33119924

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 her own behalf. [redacted], appeared as a witness for the Appellant, and provided testimony on her behalf.

[redacted] (CMH), represented the CMH. [redacted] appeared as a witness for the Department.

ISSUE

Did CMH properly determine that Appellant did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH?

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 [redacted] Medicaid beneficiary. (Exhibit 1).

2. The Appellant is an enrolled Medicare participant and has Medicaid coverage as a Qualified Medicare Beneficiary (QMB). The Appellant is not enrolled in a Medicaid Health Plan. (Exhibit 1).

3. Appellant received outpatient therapy services from [redacted], an agent of CMH from approximately [redacted]. The Appellant received the [redacted] outpatient therapy for anxiety and depression. (Exhibit 1, page 1; Exhibit 2; testimony from Appellant).

4. At some time after [redacted], the CMH no longer contracted with [redacted] to provide outpatient therapy.

5. The Appellant's non-CMH primary care physician prescribes her Valium and Xanax. (Exhibit 1, page 1).

6. In [redacted], the Appellant requested CMH services from [redacted]. The Appellant asked specifically for [redacted] to provide outpatient therapy. (Exhibit 1 pages 1-12).

7. On [redacted], the Appellant was provided an access screening. The CMH access screen determined that Appellant had a mental illness that was expected to last six months or longer, but her signs and symptoms were not intense enough to qualify as a serious mental illness defined in the Diagnostic and Statistical Manual for Mental Diseases (DSM). (Exhibit 1, pages 12-13).

8. The [redacted] screening showed no substantial impairment in activities of daily living, and did not meet medical necessity criteria for specialized supports and services.

9. On [redacted] the CMH sent an Adequate Action Notice to the Appellant indicating that her psychiatric services would be denied. (Exhibit 1).

10. The Appellant requested a Second Opinion Access screening. On [redacted], the Second Opinion Access screening was performed and the outcome was that the CMH upheld its denial. (Exhibit 1, page 16-18).

11. The Appellant's request for hearing was received 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 she 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] 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 CMH representative [redacted] for adult mental health services, stated that the Appellant requested outpatient therapy from [redacted] and was provided an initial access screening on [redacted]. The CMH representative explained the access screening process used by the CMH, elaborating that the access screening tool asked many

questions geared toward determining whether a person has a serious mental illness that substantially impairs their daily living activities. The CMH introduced document evidence of the Appellant's answers derived during the access screening such as:

> Does the Appellant feel depressed?-yes
> Does the Appellant hear voices or see things other people do not hear?- no,
> Did the Appellant have a plan to hurt themselves in the prior two weeks?-no,
> Does the Appellant feel the need to be hospitalized?-no.
> (Exhibit 1, pages 1-12)

The CMH witness explained that the access screening's overall findings were that while the Appellant had a mental illness, the Appellant did not have psychiatric symptoms of the intensity to be considered a serious mental illness or substantially impair her daily living activities. (Exhibit 1, page 7).

The CMH representative further explained that the CMH must follow the Department's Medicaid Provider Manual, when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid provider manual.

The *MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1* and Exhibit 3.1.1, Section III(a) Access Standards-*10/1/08, page 4,* directs a CMH to the Department's Medicaid Provider Manual for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, January 1, 2011, page 12-13.

CMH witness [redacted] stated that CMH utilized *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section* to determine the Appellant did not meet medical necessity to receive specialized mental health services provided through the CMH. (Exhibit 1, pages 19-20).

The Appellant testified that from [redacted] she had received outpatient therapy from [redacted]. The CMH witness clarified that the Appellant requested outpatient therapy from [redacted], but the CMH no longer contracted with [redacted] to provide outpatient therapy.

The CMH witness explained that after the access screening determined the Appellant did not meet the criteria for Medicaid-funded CMH services as a person with serious mental illness, it referred the Appellant to the [redacted] organization, which provides outpatient therapy services, but the Appellant refused the referral.

The Appellant testified that her reason for refusing the referral was because the [redacted] organization made patients pay the Medicare co-pay for outpatient therapy. The CMH representative responded that because the Appellant was enrolled in Medicaid, [redacted] would bill Medicaid the co-pay and the Appellant would have no co-pay costs to pay. The Appellant explained that [redacted] did not know or did not do billing to Medicaid for the Medicare co-pay and that she continued to have an outpatient balance from previous services at [redacted]. The CMH representative and witness explained that they have provided training to several therapy providers, including [redacted], on how to bill Medicaid so that Medicaid would cover the Medicare co-pay for outpatient therapy services.

The Appellant's [redacted] testified that she and her [redacted] lived out-of-state for several years, but in telephone conversations with their [redacted], they noticed that their [redacted] was having

mental health issues. The Appellant's [redacted] testified that she and her [redacted] moved back to Michigan because her [redacted] mental health issues were increasing.

The Appellant's [redacted] asked several questions about the determinations the access center made to based on the way the Appellant answered the access screening questions. The Appellant's [redacted] stated she believed it was for the access tool assessor to find the Appellant was agitated and irrational, but not overall mentally ill. (Exhibit 1, page 3). The CMH witness explained that the individual findings are considered overall, and considered whether attributed to a person's disabilities. The CMH witness further explained that while the CMH agreed that the Appellant may have mental health issues, the mental health issues did not substantially impair her activities of daily living.

The Appellant's [redacted] also asked several questions the access screening questions related to the way the Appellant answered the questions. The Appellant's [redacted] pointed out that while the Appellant may have indicated that she did not have problems with sleep and did not have problems with appetite, in fact her [redacted] did have problems with sleep and appetite. When asked by this Administrative Law Judge why she answered no, the Appellant stated she did not understand the question when asked. The Appellant said she felt depressed at times. At all times during the hearing the Appellant appeared alert, competent and able to clearly articulate her position.

This Administrative Law Judge is limited in scope of jurisdiction, to reviewing the information the CMH had at the time it made its decision and to compare the information to Medicaid policy to determine whether the CMH properly applied policy.

[redacted] provided credible evidence that the Appellant did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH. The CMH sent proper notice of service authorization denial. The Appellant did not provide a preponderance of evidence that she met the Medicaid Provider Manual eligibility requirements for Medicaid specialized outpatient mental health benefits 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 did not qualify for Medicaid specialized outpatient mental health benefits provided by the CMH.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

_____

Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
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cc: [redacted]

Date Mailed: 3/25/2011

***** 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.