STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2011-1678 CMH
Case No. 79451142

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. Her witnesses were [redacted] and [redacted]. [redacted] represented the Department. Her witnesses included: [redacted]. Also in attendance, but not testifying was [redacted].

ISSUE

Did the Department properly deny the Appellant's request for Individual Therapy for lack of medical necessity?

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. (Appellant's Exhibit #1)

2. The Appellant receives services from the CMH contractor, [redacted] including ACT, CLS, targeted case management, and Clubhouse. (Department's Exhibit A, pp. 17, 26)

3. The Appellant is afflicted with Major Depressive Disorder, recurrent, moderate, Asperger's Pervasive develop [sic] NOS, or Rett's disorder, attention-deficit/hyperactivity disorder hyperactive or combined. (Department's Exhibit A, p. 27, and Appellant's Exhibit #1)

4. The Appellant is identified as a person with developmental delay. (Appellant's Exhibit #1)

5. The Appellant is a brittle diabetic. (Department's Exhibit A – throughout.)

6. On assessment in [redacted] the Appellant was found to be not eligible for independent living and that Individual Therapy was not medically necessary. (See Testimony of [redacted] and Department's Exhibit A, pp. 30, 31)

7. On [redacted], the Department advised the Appellant, by Adequate Action Notice, that her request for Individual Therapy was denied as not medically necessary to be effective [redacted]. (Department's Exhibit A, pp. 36, 37)

8. The Department's notice also included her further appeal rights. (Department's Exhibit A , pp. 36, 37)

9. The instant request for hearing was received by the State Office of Administrative Hearings and Rules 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

> 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. [redacted] Community Mental Health Authority ([redacted]CMHA) 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. [redacted] functions as one of [redacted]CMHA's contractors for persons with mental illness.

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

As a person afflicted with a serious mental illness (Major depressive disorder) and a developmental disorder the Appellant is entitled to receive services from the CMH. *See* Medicaid Provider Manual, (MPM) Mental Health [ ], Beneficiary Eligibility, §1.6, January 1, 2011, pp. 3, 4 and MCL 330.1100d(3).

However, the construction of those services[1] and supports are not static, but rather subject to review by mental health professionals confirming that a current functional impairment and a current medical necessity exists for those specialized services and supports.

Medical Necessity is defined as:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most

[1] INDIVIDUAL/GROUP THERAPY - Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker. MPM, *Supra* §3.11, p. 18

cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

MPM, *Supra* §1.7, p. 5

* * *

MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

*** * ***

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 DECISIONS

Using criteria for medical necessity, a PIHP 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, *Supra*, §§2.5 – 2.5.D, pages 13, 14.

***

The Appellant testified that she would benefit from individual therapy to help her "move forward and become a productive member of society." The Appellant's [redacted] believed that individual therapy would assist the Appellant in "overcoming problems expressing herself." Furthermore they stated that one-to-one therapy was a necessary element in achieving her goal of independent living.

The Appellant testified that she did have a hard time communicating how she feels – although this testimony was in direct opposition to the [redacted], evaluation conducted by [redacted]. [*See* Department's Exhibit A, sub 5 at page 30]

The Department witnesses testified that the Appellant has a full array of services – including ACT.[2] [redacted] observed that the Appellant participated weekly in her group therapy sessions where she reported her chief concern as being better able to deal with her then present living situation. She added that she had no struggle communicating. She reported that the Appellant's diagnosis at that time included Major Depression, Asperger's syndrome and diabetes - which the Appellant was managing poorly. [redacted] agreed that there was nothing the Appellant could learn from individual therapy that she was not achieving "in group." *See* Testimony of [redacted].

[2] A comprehensive set of services standing alone ACT [Assertive Community Treatment Program] provides, in part: … a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. Michigan adopted a modified ACT model in the 1980's tailored to Michigan service needs. While a PIHP is free to use either the Michigan ACT model or the federal Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model, with prior Department approval, the use of the Michigan model is strongly encouraged. ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team. All ACT team staff must have a basic knowledge of ACT programs and principles acquired through MDCH approved ACT specific training within six months of hire, and then at least one MDCH approved ACT specific training annually. MPM, *Supra* §4, pp. 23-26

In closing, the Appellant's [redacted] argued that the family did not understand how individual therapy could not be tried. The answer to this rhetorical question is that qualified clinicians reviewed the Appellant's plight and the instant request for service [Individual Therapy] and determined, in their professional judgment, that such therapy was not medically necessary and that the services received by the Appellant at the time of request were adequate in scope, duration and intensity to achieve her stated goals – as the Department's evidence documented. See Department's Exhibit A – throughout.

It is clear that the Department did not arbitrarily deny Individual Therapy services to the Appellant, but rather properly assessed the Appellant's panoply of services in relation to her clinical progress and symptomology.

The Appellant failed to preponderate her burden of proof that the Department erred in its denial of Individual Therapy services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant's request for Individual Therapy for lack of medical necessity.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/16/2011

***** 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.