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

IN THE MATTER OF:

Docket No. 2011-29569 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]. The Appellant appeared without representation. Her witness was her neighbor, [redacted]. [redacted], Clinical Director, represented the Department. Her witnesses were [redacted].

PRELIMINARY MATTER

The admission of Exhibits B and C were taken under advisement at hearing. On review, Exhibit B is admitted, but was afforded little weight on review. Exhibit C was inadmissible hearsay. It was not admitted.

ISSUE

Did the Department properly terminate the Appellant's Outpatient Therapy and medication services 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 a [redacted]-year-old Medicaid/SSI beneficiary. (Appellant's Exhibit #1)

2. The Appellant had received the services of Outpatient Therapy and medication services for treatment of her Borderline Personality Disorder (BPD). Those services were terminated and her case was closed with an effective date of [redacted] (Department's Exhibit A, pp. 2-4)

3. The Appellant is afflicted with Fibromyalgia, migraines and BPD (stable). (Department's Exhibit A, pp. 6 and 33)

4. The Appellant is identified as a person who no longer needed mental health services having achieved her goals after “several years” of therapy. (Department’s Exhibit A, p. 35)

5. The Appellant is concerned about the status of her SSI disability benefit. (Appellant’s Exhibit #1, p. 2 and See Testimony of Marshall)

6. On discharge assessment the Appellant’s therapist recommended discharge because the Appellant had mastered DBT and coping skills. She was described as “a capable and independent person.” (Department’s Exhibit A, p. 35)

7. On [redacted], the Department advised the Appellant, by Advance Notice of Action, that her ongoing mental health treatment would be discontinued for lack of medical necessity with an effective date of [redacted]. Her further appeal rights were contained therein. (Department’s Exhibit A, pp. 3 and 4)

8. The instant request for hearing was received by the Michigan Administrative Hearing System for the Department of Community Health 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. Ionia County Community Mental Health SP contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by the 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.

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

However, the provision of those services[1] and supports are not static, but rather recede or expand subject to review by mental health professionals confirming that a current functional impairment and a current medical necessity exists for continued receipt of those specialized services and supports. Such was the process of assessment of the Appellant for discontinuation of her services. Mental health professionals determined that she no longer met the criteria as one afflicted with a serious mental illness.

The Department's Medicaid Provider Manual (MPM), Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5 explains the criteria utilized to make supports and services decisions under the rubric of medical necessity. The MPM states:

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[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.

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 person-centered 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. (Emphasis supplied)

MPM, §2.5B, p. 13, April 1, 2011

The Department witness, , testified that the Appellant had made significant progress over the last year and that discontinuation of therapy coincided with her therapist's departure from employment with the CMH.

testified that the Appellant's therapist was skilled in the areas of DBT and cognitive behavior and was considered to be both an expert and "teacher" of others. She said that her employee was a "skilled clinician" who rendered such service to the Appellant having titrated her necessary sessions down to once a month after having developed "self worth and control" in her patient [the Appellant].

Hamilton added that the Appellant had demonstrated independence in the community and had achieved her goals – thus in her professional opinion mental health services were no longer medically necessary – a view also held by the Appellant's former therapist.[2] *See* Department's Exhibit B – throughout.

Following a medication review and assessment the Appellant was determined to be stable and to present with only "mild" symptoms.

[2] The therapist was not called to testify.

Department witness [redacted] testified that the Appellant could be followed by her primary care physican. She said that at present the Appellant's status [level of care] does not require a psychiatrist.

The Appellant testified that she was never contacted by the psychiatrist, had medication adjustment issues and said further that she was not ready to move on owing to other situations and abandonment issues over which she still struggles.

Her witness, neighbor [redacted], said that the Appellant has had set backs within the last two months – that she was "antsy" and "gets so mad" that she slams doors.

The Department's crisis staff employee [redacted] testified that the Appellant was a regular caller [2-4 times a week] in [redacted] which was subsequently reduced in each of the following years – so that by [redacted] the Appellant no longer used the crisis line.

Her witness [redacted]] said the Appellant remained "mad and moody."

The Appellant must prove by a preponderance of evidence that the CMH denial of continued therapy and medication services was a decision reached in error. The CMH provided credible evidence that the Appellant had made significant progress and that she no longer met the criteria for medically necessary mental health treatment. Even still - at hearing the Appellant displayed the sudden despair of one separating from her routine of services long provided by mental health professionals she had come to trust.

However, the objective evidence supported the Department's assessment that the Appellant had sufficiently improved over the years such that hers was no longer a serious mental health issue – but rather a mild condition which could be followed by her family doctor. Reassessment procedures were explained to the Appellant on the record should an emergent situation present – but the Department's decision was proper when made.

DECISION AND ORDER

The CMH's denial of continued therapy and medication services for the Appellant was proper when made.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc:

Date Mailed: ______________________

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.