STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM
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IN THE MATTER OF

Docket No. 2011-33407 CMH
Case No. 204314480

[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]. Appellant [redacted] appeared on her own behalf and provided testimony.

[redacted], [redacted] County Community Mental Health (CMH), Fair Hearing Officer, represented the CMH.

ISSUE

Did CMH properly terminate Appellant's case management and individual therapy services?

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 beneficiary at time of hearing.

2. The Appellant is enrolled in [redacted] County CMH.

3. Appellant was authorized for the following services from CMH through her [redacted] Person-Centered Plan: individual therapy services (individual therapy), group therapy, and monthly medication reviews. (Exhibit A, p 4).

4. Leading up to the [redacted] Person-Centered Plan, the Appellant had engaged in and graduated from a year-long Dialectical Behavior Treatment (DBT) program. DBT is a combination of group and individual therapy that assists in developing skills to navigate through life. (CMH-Hearing Summary).

5. Beginning in [redacted] the Appellant began to conclude her individual therapy sessions with the individual therapy terminating by the end of [redacted]. (Appellant testimony).

6. On or around [redacted], the Appellant requested individual therapy. (Exhibit 1, p 1).

7. On [redacted], the CMH sent an Advance Action Notice to the Appellant indicating that her request for individual therapy services was denied. (Exhibit 1, p 1).

8. The Appellant's request for hearing was received on [redacted]. (Exhibit 2). The Appellant contested the denial of short-term individual therapy.

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. 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.

The Appellant testified that although she knew her individual therapy was coming to a conclusion, and eventually ended, she believed she was in need of resumed individual therapy because new issues had occurred in her life. The Appellant said she had learned that the reason her individual therapy had ended and she had been denied resumed individual therapy was because her therapist had left the agency, and the agency had changed its policy to provide individual therapy only to clients who had court-ordered therapy services.

Individual therapy is a Medicaid-covered service and the Department contracts with CMH to provide medically necessary individual therapy to CMH enrollees. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* sets out the medical necessity eligibility requirements, in pertinent part:

> **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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2011, page 13.

The CMH must base its denial or termination of individual therapy services on medical necessity and not on its agency's lack of individual therapy staff therapists. In responding to this Administrative Law Judge's questions regarding medical necessity, the CMH representative explained that CMH based its decision on medical necessity; that Appellant had been receiving individual therapy as part of a year-long DBT course, had successfully graduated from the course, and therefore the individual therapy was no longer medically necessary.

In reviewing the Appellant's person-centered-plan, the provision of individual therapy is not absolute, rather, the language reads, '[redacted] will continue in group and individual psychotherapy for as long as possible."

While this Administrative Law Judge expresses concern about the Appellant's testimony that the reason for denial of individual therapy is insufficient availability of individual therapy staff, the CMH provided evidence to support the assertion that the denial of individual therapy was because it was no longer medically necessary for the Appellant.

The Appellant must prove by a preponderance of evidence that the CMH denial of individual therapy services was not proper, but Appellant's testimony did not reach the preponderance level. It is noted that this Decision and Order does not preclude the

Appellant from requesting individual therapy services from CMH in the future if she believes it is medically necessary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

The CMH's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 12/22/2011

***** NOTICE *****

The Michigan Administrative Hearings 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 Hearings 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.