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:

[REDACTED],

Docket No. 2011-41748 CMH
Case No. 56776272

Appellant
________________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, an in person hearing was held [REDACTED]. Appellant [REDACTED] appeared and testified on her own behalf. [REDACTED], Appellant's Deaf Services Case Manager was present, but did not testify. [REDACTED], an interpreter for deaf individuals, was sworn in and provided an interpretation of and for the Appellant who is deaf.

[REDACTED], Due Process Manager for [REDACTED] County Community Mental Health (CMH), represented and gave testimony for the Department (MDCH). Ms. [REDACTED], MS, LLP, Utilization Care Coordinator for CMH's Utilization Management Department, [REDACTED] appeared as a witness for the Department.

ISSUE

Does the Appellant meet the medical necessity or eligibility requirements for Medicaid Specialty Supports and Services through 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 a [REDACTED] year old (DOB [REDACTED]) Medicaid Beneficiary, who was receiving Medicaid Specialty Services and Supports of Targeted Case Management, Medication Reviews, and Community Living Supports from a CMH program called Next Step. (Exhibit 1). Appellant also is eligible for

Medicare.

2. CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.

3. CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.

4. On , , MS, LLP, a Utilization Care Coordinator for CMH's Utilization Management Department completed a special audit or eligibility review of the Appellant's clinical records. Ms. determined that the Appellant no longer met the medical necessity for targeted case management, and further that she no longer met the eligibility criteria as a person with a serious mental illness required to receive services from CMH. (Exhibit 2).

5. On , CMH sent the Appellant written advance notice that she was not eligible for services through CMH as a person with a severe mental illness and that her case management with Deaf Services, medication clinic, Next Step, and PsychoSocial Rehab (PSR) were terminated effective . The notice informed Appellant of her right to a fair hearing. (Exhibit 3).

6. On , MAHS received the Appellant's request for an Administrative Hearing. (Exhibit 10).

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—

Under approval from the Center for Medicaid and Medicaid Services (CMS) the Michigan Department of Community Health (MDCH) operates a section 1915(b) waiver called the Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the MDCH to provide services under the Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. CMH must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, amended, and those services/supports included as part of the contract between the Department and CMH.

Ms. , a limited licensed psychologist with CMH, testified that she completed a special audit or eligibility review of Appellant's clinical records on . (Exhibit 2). Ms. reviewed Appellant's medication reviews dated and , (Exhibit 4); the Individual Plan of Service effective through , (Exhibit 5); Periodic Review Notes dated and , (Exhibit 6); and, progress notes dated – , (Exhibit 7). The criteria for eligibility for an adult with a serious mental illness are listed on Exhibit 2.

Ms. stated she found the Appellant did not meet any of the criteria for eligibility for CMH services as an adult with a serious mental illness. Furthermore, Appellant did not meet the medically necessary criteria for Medicaid specialty services. Ms.

determined the Appellant was diagnosed with dysthymic disorder by CMH psychiatrist Dr. which is not considered to be a serious mental illness. Ms. stated there was nothing in the clinical records to support a finding of a serious mental illness, only a possible flare up of depression, but no showing of clinical incapacities. Appellant was reported as working, she was stable at that time, and was doing very well. There was no documentation to show that Appellant was mentally retarded or developmentally disabled.

Ms. stated the records indicated Appellant was able to live independently and functioned quite adequately. She owns a car and a house. Appellant was only using case management services to monitor very basic everyday activities that she could perform for herself. Ms. stated Appellant had a work history and her ADL's were reported as being good. Appellant presents with few if any deficits in her overall daily functioning. Ms. stated there was nothing in the records to support a determination that Appellant was not capable of completing activities of daily living for the most part on her own.

Ms. stated Appellant did not present with medical necessity for ongoing case management services, or Next Step and she did not present as eligible for services as a severely mentally ill person. Ms. stated she prepared the advance action notice on , which was sent to the Appellant terminating her CMH services effective . (See Exhibit 3). Ms. stated Appellant has Medicare, and Medicare would cover Appellant's physician's appointments. If Appellant needed medications only, or counseling services, she could receive services from a provider who could bill Medicare.

This Administrative Law Judge does not have jurisdiction to order CMH to provide Medicaid covered services to a beneficiary who is not eligible for those services. This Administrative Law Judge determines that the Appellant is not eligible for CMH Medicaid covered services for the reasons discussed below.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6* makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual provides:

> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and

degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). <u>The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</u>	The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical

	director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2011, page 3.

The definition section contained in the Mental Health Code, specifically MCL 330.1100d(3), defines “Serious Mental Illness” as follows:

> (3) “Serious mental illness” means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> (a) A substance abuse disorder.
>
> (b) A developmental disorder.
>
> (c) A “V” code in the diagnostic and statistical manual of mental disorders.

The Department’s *Medicaid Provider Manual, Mental Health and Substance Abuse, Targeted Case Management, Section 13* describes Targeted case management and the various services that may be included. This section of the manual states in part:

> **13.2 DETERMINATION OF NEED**
>
> The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary’s record.

Section 13.3 Core Requirements also sets forth additional requirements for the provision of case management services. These requirements include: assessments must be updated when there is significant change in the condition or circumstances of the beneficiary; the individual plan of services must also reflect such changes; the plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs); a formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction; and, targeted case management shall not duplicate services that are the responsibility of another program.

Medicaid Provider Manual, Mental Health and Substance Abuse, Targeted Case Management, Section 13, July 1, 2011, pp. 67-68.

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.B. 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, Medical Necessity Section, July 1, 2011, p. 13.

Appellant testified that she sometimes goes to PSR to socialize and to visit people and have fun together. She stated she made mistakes and had to learn the process about her money and to be very careful. Appellant continues to take various medications including Prozac, Metformin, Lipitor, Calcium, and has to poke her finger to check her blood sugar as she has diabetes. At this time she feels she can handle things on her own, but might need Shawn Gray her case manger to help her if something really comes up.

Appellant acknowledged that she had a primary care physician. She stated she has a job as a janitor. She owns her own home. She has a car that she paid for and it runs pretty well right now. [redacted] has helped her with getting tires and oil changes for her car. Appellant states she receives food for low income individuals at her church. She hasn't decided whether she wants to go to college.

In this case, CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid Covered mental health services and properly determined she is not. Appellant's diagnosis of dysthymic disorder is not a qualifying diagnosis for Medicaid eligibility as a person with a severe mental illness. The testimony and clinical records contained in the record does not show any clinically significant residual disability, symptoms, or impairments. There is no showing of a need for specialized services to address any such residual symptoms or impairments, or to prevent a relapse. (See Exhibit 2).

Furthermore, the evidence does not establish a medical necessity for ongoing case management or Next Step services. [redacted] correctly pointed out that medical necessity means that an individual requires a particular service or an ongoing service to prevent serious decompensation, or because they would be unable to maintain some semblance of relatively normal functioning without that service. The evidence contained in the record does not support such a finding. Rather, the Appellant is stable and able to function quite adequately on her own. Appellant owns a home and a car. She is also employed as a janitor. The evidence shows the Appellant is capable of completing her activities of daily living for the most part on her own. Accordingly, she is not currently entitled to receive Medicaid services through CMH. Any further medical services or counseling services that the Appellant might require could be covered by Medicare.

DECISION AND ORDER

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

The CMH properly determined that the Appellant does not meet the medical necessity or eligibility requirements for Medicaid Specialty Supports and Services through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 9/16/2011

***** NOTICE *****
The State Office of Administrative Hearings and Rules for the Department of Community Health 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 Administrative Tribunal 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.