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. 2011-43160 CMH
Case No. 62474787

[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 [redacted] was present and provided testimony.

[redacted], [redacted] Community Mental Health (CMH), Fair Hearing Officer, represented the CMH. [redacted], LLBSW, Case Manager, [redacted], appeared as a witness for the CMH.

ISSUE

Did CMH properly terminate Appellant's case management and psychiatric 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.

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

3. Appellant was receiving case management services (CMS) and psychiatric services (PSS) from CMH in [redacted] and [redacted] as authorized in his [redacted] Person-Centered Plan (PCP). (Exhibit E). Appellant was receiving CMS through CMH's agent Touchstone Innovare. (Exhibit E).

4. In [redacted], CMH listed Appellant as having an Axis I diagnosis of schizoaffective disorder and an Axis II diagnosis of mild mental retardation. (Exhibit E).

5. In his [redacted] PCP, Appellant was authorized for case management one to two times per month and medication review once every three months from [redacted] to [redacted] and again from [redacted] to [redacted]. (Exhibit E)

6. The record indicates that Appellant was a "no show" for 7 of his 8 medication reviews from [redacted] to [redacted]. Appellant was also a "no show" or cancelled 14 of his 15 appointments with his case manager during the same time period. (Exhibit E)

7. As a result of Appellant's failure to appear and failure to use his mental health services the CMH determined his case could be closed. (Exhibits C, D).

8. On [redacted], the CMH/T[redacted] [redacted] sent an Adequate Action Notice to the Appellant indicating that his case management services would be terminated. (Exhibits C, D).

9. The Appellant's request for hearing was received on [redacted]. (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. 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 CMH/T[redacted] case manager witness [redacted] testified that because the Appellant was not utilizing his case management services and medication review services it was determined that his case management and medication review services would be terminated and, because the two services were the only ones he was currently receiving, his CMH case could be closed.

During the hearing, the CMH introduced evidence of the fact that Appellant was authorized for CMH case management and psychiatric services but had failed to appropriately utilize the services in [redacted] and [redacted]. (Exhibit E). The evidence also showed that the Appellant could receive mental health medications through his primary care physician.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual 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 personcentered 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.

2.5.D. 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 2, 2011, page 13-14.

The Appellant testified that he had trouble getting transportation to and from his appointments with CMH/T[redacted] and that his mother also had difficulty providing him transportation. The Appellant said that he continued to obtain his medications by calling the nurses station at [redacted] and he understood that he could continue to get his psychiatric medications through his primary care physician.

The Appellant must prove by a preponderance of evidence that the CMH termination of CSM and PSS services was not proper, but he was unable to do so. The CMH provided credible evidence that its termination of case management and psychiatric services was not improper given that Appellant failed to utilize the services provided over an extended period of time, and therefore he was unable to establish a medical necessity for the service.

DECISION AND ORDER

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

> The CMH's termination of Appellant's case management and psychiatric services was proper.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: **9/6/2011**

***** 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 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.