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. 2011-48404 CMH
Case No. 5959309

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 Wednesday, [redacted]. [redacted], Appellant's Case Manager with [redacted], appeared and testified on behalf of Appellant. Appellant [redacted] also appeared and testified in her own behalf. [redacted] the Director of [redacted] was present but did not testify.

Ms. [redacted], Hearings Coordinator, [redacted], represented the CMH. [redacted] Utilization Manager for [redacted] appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny 2 months and 18 units of Appellant's Case Management Services (CMS)?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] County Medicaid beneficiary eligible to receive services through [redacted], the Community Mental Health (CMH) Agency serving [redacted] and [redacted] Counties.

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant is a [redacted] year-old (DOB [redacted]) Medicaid beneficiary. The Appellant is diagnosed with Major Depressive Disorder, recurrent without psychosis, and by history with PTSD and early stages of Alzheimer disease. (Exhibit 1, p. 3 and Attachment K, p. 42).

4. The Appellant currently resides at [redacted], a licensed adult foster care home in [redacted], MI. (Exhibit 1, p. 3 and Attachment G, p. 15).

5. Appellant was receiving Case Management Services through Hope Network, which included Community Living Supports provided by the Life Span PICC Program, and psychiatric treatment through LifeWays physicians' unit. (Exhibit 1, Attachments D & G, pp. 15-20).

6. On [redacted], a Specialist Review was completed by [redacted] Utilization Management Director regarding Appellant's request for Case Management Services (CMS). [redacted] stated eligibility criteria for CMS not present, that the information to support continued CMS was minimal at best. Information from [redacted] Network indicates the Appellant is residing in an AFC home which is monitoring her medical issues and medication compliance. Ms. [redacted] recommended approval of only 1 month or 4 out of 22 units of CMS to allow for case closure and referral to DHS Model Payment Services (MPS). (Exhibit 1 p. 3 and Attachment A, p. 8).

7. On [redacted], [redacted] Utilization Manager for the CMH denied 2 months and 22 units of CMS. (Exhibit 1, p. 3, and Attachment B, p. 9).

8. On [redacted], the CMH sent an action notice to the Appellant indicating that 2 of the 3 months and 18 of the 22 units of Case Management Services requested were denied. The notice indicated that the intensity of the service was not supported. No medical necessity for continued case management. There were no specialized needs identified at this time. The case was closed to Case Management and was referred to DHS. (Exhibit 1, Attachment C, p. 10).

9. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 1, Attachment F, p. 14).

10. On [redacted], Appellant filed a local appeal of the denial of CMS. (Exhibit D).

11. On [redacted], a local appeal resolution was issued by [redacted] Utilization Manager [redacted] upholding the denial of CMS. Ms. [redacted] stated Appellant does not meet medical necessity for case management services. As a resident of an Adult Foster Care Home, Appellant would be obtaining services designed to maintain and improve Appellant's physical and intellectual functioning and well being. Referral to DHS does not require continued case management services.

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.
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> *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) 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 and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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.*

CMH witness Ms. [redacted] testified she was a [redacted] Utilization Manager. Ms. [redacted] was responsible for denying the requested treatment. She reviewed Appellant's treatment plan for [redacted] through [redacted], and her progress notes. Ms. [redacted] stated that the Appellant appeared to have met all of her treatment goals one month into the plan.

Ms. [redacted] stated the case management goal of achieving optimum physical and mental health had been met. Appellant was regularly attending her medical appointments, and it was the responsibility of the [redacted] AFC home to make sure she kept her appointments. Appellant was taking her medications as prescribed and reporting any side effects. Appellant was also doing her chair exercises and walking around town. According to the treatment plan, it was the responsibility of the AFC home to obtain and administer medications, transport Appellant to appointment, and contact physicians when necessary. (See Licensing Rules for AFC Homes, Exhibit 1, Attachment N, pp. 46-47).

Another of Appellant's stated goals was the building of relationships and she was receiving CLS towards this goal. The progress reports show that she was building relationships with staff and residents at the AFC home. Appellant was also increasing communications within the AFC home. Ms. [redacted] stated there was no evidence of any difficulties communicating with the AFC staff. It was noted that the AFC home is responsible for providing social and recreational activities, which is duplicative of some of the CLS services that were being provided. Ms. [redacted] stated that there was no showing of medical necessity for continuing the CLS services.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Targeted Case Management, Section 13, p. 67*, describes Targeted Case Management and the various services that may be included. This section of the manual states in part:

> Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and

other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

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 *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Michigan Medicaid policy distinguishes what tasks are covered under community living supports:

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, (that exceeds state plan for adults) prompting, reminding, cueing, (revised 7/1/11), observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP case manager or supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization amount, scope and duration of Home Help does not accurately reflect the beneficiary's needs based on findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and nonmedical services

➢ Reminding, observing and/or monitoring of medication administration

➢ Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan Personal Care services. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

MPM, Mental Health and Substance Abuse Section, July 1, 2011, pp. 106-107.

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve her goals. 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.

[redacted], Appellant's Case Manager with [redacted] Network testified Appellant is a cutter and has been receiving mental health treatment for 40 years. Ms. [redacted] indicated Appellant wants to stay with the Life Span PICC program and continue receiving CLS as they have helped her and she has not cut with the last 2 years while receiving this service. Ms. [redacted] stated Appellant's church and the [redacted] home are in the country and Appellant is not that familiar with the community of [redacted]. She is just starting to develop community supports. Appellant is starting to interact with others at the AFC home, but in the cold weather there is not as much interaction. Ms. [redacted] stated Appellant feels that she needs an advocate to assist her with her physical and mental health needs.

Appellant testified that PICC has helped her tremendously. It has given her the opportunity to meet and spend time with other people. This has improved her mental health and makes her feel more alive. Appellant believes if she did not receive the CMS and CLS services that her mental health would decline. She said she has had thought of cutting but she hasn't done it. Appellant had therapy in the past and feels it did not help her. She feels it helps her to have the services through the PICC program.

The CMH utilization manager reviewed all available information relating to Appellant's needs for Case Management Services including the treatment plan and the progress notes submitted. The information showed that all of Appellant's treatment goals had been met. Appellant was living in an AFC home that was meeting her needs, and case management services may not duplicate services that are the responsibility of another program. Furthermore, the CMH utilization manager could not find the need for any specialized mental health services for Appellant at this point in time. Accordingly, it was determined that continued CMS services were not medically necessary and the CMH properly cancelled 2 months or 18 out of the 22 units of CMS services previously authorized.

This administrative law judge is limited to the evidence the community mental health had at the time it made its decision. The Appellant bears the burden of proving by a preponderance of the evidence that the additional CMS services requested are

medically necessary. Applying the evidence the CMH had at the time it made its authorization decision in [redacted] supports the CMH position that additional CMS services are not medical necessity. The Appellant did not meet her burden to establish medical necessity for additional CMS services determined not to be medically necessary by CMH in accordance to Medicaid policy and the Code of Federal Regulations (CFR).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly denied 2 months and 18 units of Appellant's Case Management Services (CMS).

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 10/03/2011

***** 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.