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. 2011-48407 CMH
Case No. 13774574

[redacted],

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. The Appellant was represented by [redacted], a Certified Peer Support Specialist with Recovery Institute. [redacted] was present and gave testimony in his own behalf.

Attorney [redacted], Corporation Counsel for [redacted] County Community Mental Health and Substance Abuse Services, hereinafter CMH, represented the CMH. Ms. [redacted], MA LLP, Utilization Review Coordinator for [redacted] Michigan Affiliation PIHP Quality Department an affiliate of the CMH, was present and gave testimony on behalf of the CMH. [redacted], Customer Service Representative for CMH Agency was also present and provided testimony at the hearing.

ISSUE

Did the CMH properly deny Appellant's request for Case Management services based upon a finding that Assertive Community Treatment (ACT) services were medically necessary?

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 Medicaid beneficiary who has been a recipient of mental health services his entire life.

2. [redacted] County Community Mental Health and Substance Abuse Services is the Community Mental Health contractor with the State of Michigan. (hereinafter CMH)

3. The Appellant is a participant with CMH and started receiving ACT services through [redacted], an agency who contracts with the CMH to provide ACT services, on [redacted]. His Act level services include a payee and peer support.

4. The Appellant has been diagnosed with schizophrenia undifferentiated type, mild mental retardation, alcohol abuse, and bipolar disorder, NOS. (Exhibit A, p. 7).

5. On [redacted], Appellant filed an appeal requesting that he be transferred or stepped down from ACT to Case Management services.

6. On [redacted], Ms. [redacted], MA LLP, Utilization Review Coordinator for [redacted] Michigan PIHP, an affiliate of the CMH conducted a Utilization Management Review. Ms. [redacted] recommended that Appellant's ACT services be continued. (Exhibit A).

7. On [redacted], Appellant was sent a letter by CMH advising him that they were upholding their authorization of ACT services and denying his request to step down to Case Management services. Appellant was advised he could have a state-level appeal and was provided with a Hearing Request form and envelope if he wanted to appeal.

8. The Appellant's request for hearing was received on [redacted]. (Exhibit C).

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.

Ms. [redacted] stated she was a Utilization Review Coordinator for CMH and is a limited licensed psychologist in the State of Michigan. Ms. [redacted] reviewed Appellant's current situation and prepared the Utilization Management Review dated [redacted]. (Exhibit A). In reviewing Appellant's records she determined Appellant required varying levels of care, such as some assistance with transportation in the community, needing some prompts for proper hygiene, he has many coordination needs for housing and benefits, he had no primary care physician, he has health concerns with being under weight, and the need for assistance with challenging behaviors as evidenced by his making very frequent calls to provider and his payee assistance, he also has apparent memory issues where a provider tells him something but he later forgets and calls back with the same question.

Ms. [redacted] determined Appellant needed a higher level of care and concluded that his request for Case Management services should be denied and his ACT services should be continued. Ms. [redacted] found Appellant struggles with a developmental delay and some personality features that impede his ability to reason and understand his own needs. Appellant has a long history of quickly becoming dissatisfied with different providers and

requesting new services right away before giving the service provider the chance to help him. Ms. [redacted] noted a long history of suicide gestures. He can be verbally aggressive without resulting to violence. Appellant has poor memory, poor insight, and shows poor judgment. He also has a long history of psychiatric hospitalization.

Ms. [redacted] Appellant has a diagnosis of alcohol dependence although he denies using alcohol. Ms. [redacted] stated within the past month Appellant became homeless for about two and a half weeks when he insisted on moving out of his rental situation. The provider advised he could not afford a hotel he wanted to go to, and when he ran out of money he became homeless. Ms. [redacted] stated at the time he went to the ER and the hospital frequently for a place to stay and he tested positive for both methamphetamine and Vicodin according to a report made by ACT staff.

Ms. [redacted] stated Appellant was hospitalized in the inpatient psychiatric ward at [redacted] Hospital from [redacted] to [redacted] due to suicidal ideation. He presented himself at [redacted] PH once after that. Ms. [redacted] stated in [redacted] Appellant hitchhiked to [redacted], MI, and told the hospital that he wanted to kill himself, so he was again hospitalized. Appellant does not present as psychotic at this time according to available documentation.

Ms. [redacted] testified Appellant has moved back and forth from [redacted] and [redacted] Counties on multiple occasions. As a result, CMH services have started and stopped a number of times. She indicated Appellant's current CMH services are ACT services, which includes a payee and peer support. Ms. [redacted] stated the Appellant was requesting a higher level of services than what Case Management would be able to provide. Act services are provided at least twice a week, but Appellant tends to call daily and wants visits several times a week. Ms. [redacted] stated Act Services can be supplemented with peer support, but Appellant requires a high number of visits to coordinate primary care, housing, and benefits.

Ms. [redacted] stated Appellant has been on Navane and Zantac for a history of ulcers. He has been diagnosed with chronic schizophrenia, alcohol dependence and mild MR. Appellant's functioning is congruent with ACT level services at this time because he had a hospitalization within the last year, he has had periods of instability, and CMH hasn't witnessed a period of stability at this point. Ms. [redacted] stated Appellant demands a high level of services even for an Act level recipient.

Ms. [redacted] stated the hearing was prompted by Appellant's desire to have Case Management services instead of ACT services. Ms. [redacted] concluded that due to Appellant's excessive demands for CMH services, his high level of distress, his many coordination needs, and his reestablishing himself in [redacted], that ACT Services were medically necessary and a step down to Case Management was not appropriate at this time. Ms. [redacted] believed a 6 month period of stability would be appropriate before Appellant could step down to Case Management Services.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. 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 is required to use a person-centered planning process to identify medically necessary services and how those needs would be met pursuant to its contract with the Department of Community Health. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

The *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section dated July 1, 2011*. It defines medical necessity as follows:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
>
> *Medicaid Provider Manual*
> *Mental Health /Substance Abuse*
> *Version date July 1, 2011, page 5.*

The *Medicaid Provider Manual* further specifies Medical Necessity Criteria:

> **2.5.A. Medical Necessity Criteria**
>
> **Mental health, developmental disabilities, and substance abuse services** are supports, services and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
> - Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
> - Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

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/aids) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professions with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on personal-centered planning, and for beneficiaries with substance use disorders, individuals 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.

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for the timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

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, fate-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/Substance Abuse Section
version date July 1, 2011 pages 12-14.

[redacted] County CMH is denying case management services for the Appellant and has authorized instead a more restrictive level of services referred to as ACT services. The services are more intense than case management services. The Appellant has asked to discontinue his ACT services and instead has requested to step down to case management services. Appellant disputes their medical necessity. CMH asserts ACT services are medically necessary for this Appellant due to his current functional and mental health status.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Assertive Community Treatment Program, Section 4* gives a description of ACT services. It states in part:

Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. Michigan adopted a modified ACT model in the 1980's tailored to

> Michigan service needs. While a PIHP is free to use either the Michigan ACT model or the federal Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model, with prior Department approval, the use of the Michigan model is strongly encouraged.
>
> ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team.

Section 4.2 identifies the target population for ACT services:

> ACT services are targeted to beneficiaries with serious mental illness, which may include personality disorders, who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.
>
> - Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication adherence.
>
> - Beneficiaries with serious mental illness with a co-occurring substance disorder.
>
> - Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.
>
> - Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
>
> - Older beneficiaries with serious mental illness with complex medical/medication conditions.

Section 4.5 provides the ACT services eligibility criteria, with regard to diagnosis, severity of illness and intensity of service.

Diagnosis
The beneficiary must have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes).

Severity of Illness
Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance.

- Self-Care/Independent Functioning - Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations.

- Drug/Medication Conditions - Drug/medication adherence and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions.

- Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Medicaid Provider manual, Mental Health & Substance Abuse Services, Section 4.5, p. 27.

The Appellant testified he would like to have Case Management rather than the ACT team. He said he had case management before for a long time. He liked working with someone long term and felt it was important to work with someone he could get along with. Appellant said he did not have trouble remembering Act team members. He also stated he now has a place to do laundry in his boarding home, so he doesn't have as many problems with personal hygiene issues.

Appellant claimed ACT team members would get mouthy with him and they were often unavailable. He would get frustrated trying to communicate with the ACT team and they did not provide him with answers when he made requests of them. Appellant indicated ACT team members did not stay very long and did not do much when they were around.

Appellant stated he liked working with [redacted], his peer support specialist. He would like to meet other people who work at [redacted] Institute and be able to interact with them. Appellant indicated that a Case Manager who could check on him twice a week would not be sufficient to meet his needs for CMH services, even if he had a regular peer companion he could talk to on a regular basis.

The credible and persuasive evidence of record demonstrates that the Appellant's current functional status is such that more intensive services are medically necessary at this time. As correctly pointed out by Ms. [redacted], Appellant's excessive demands for CMH services, his high level of distress, his many coordination needs, and his reestablishing himself in [redacted], all demonstrate that ACT Services are medically necessary and that a step down to Case Management is not appropriate at this time. A 6 month period of stability would be appropriate before Appellant could step down to Case Management Services. His request for case management services and his functional status are incongruent. CMH has presented sufficient evidence to establish that the Appellant does meet the ACT criteria set forth in policy.

> **Intensity of Service**
> ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:
>
> - An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.
>
> - The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest

> regression, and forestall the need for inpatient care or a 24-hour protective environment.
>
> - The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.
>
> - Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.
>
> - Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.
>
> - Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.
>
> *Medicaid Provider Manual, Mental Health & Substance Abuse Services, Section 4.5, pp. 27-28.*

Reviewing the intensity of services provided as ACT services it is apparent the Appellant does require the intense level of services described. CMH concluded that a step down to Case Management services would be ineffective at this time. The fact that Appellant became homeless and started seeking shelter at the hospital during his period of homelessness, and the fact that he tested positive for methamphetamine and Vicodin all following his request for a step down to Case Management services further supports the CMH decision to continue ACT Services.

This ALJ concurs with the Department's determination that the Appellant does require ACT services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] County CMH services properly denied Appellant's request for case management services and continued Act services on behalf of the Appellant.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D Bond

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

cc: [redacted]

Date Mailed: 10/03/2011

***** 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.