# STATE OF MICHIGAN STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH

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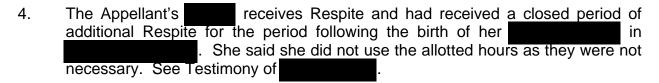
IN THE MATTER OF:		Dookst No. 2011 0054 CMU	
		Docket No. 2011-9054 CMH Case No. 30075796	
Appel	lant/		
	DECISION AND ORDE	<u>R</u>	
	is before the undersigned Administrative Law t's request for a hearing.	Judge pursuant to MCL 400.9 upon	
appeared on	otice, a hearing was held on behalf of the Appellant. Her witness was he presented the Department. Her witnesses we		
The Appellar	nt's was present.		
<u>ISSUE</u>			
	Did the Department properly deny Communit medically necessary?	y Living Supports (CLS) as not	
FINDINGS C	OF FACT		
	strative Law Judge, based upon the competent record, finds as material fact:	nt, material and substantial evidence	
1.	The Appellant is Medicaid benef	iciary.	
2.	The Appellant has been receiving services a CMH contractor for his ADHD, Combined and Autism. See Amende	medical conditions, which include	

3.

3-6 and See Testimony).

The Appellant's medical condition results in a variety of behaviors that are

addressed in person centered planning. He plays rough, does not always understand boundaries and is "a runner" and is believed to be at risk for elopement while on community based outings. (See Department's Exhibit A, pp.



- 5. The plan currently authorized by the Department consists of supports coordination, Respite, speech evaluation, occupational therapy evaluation, a behavioral health screening, behavioral management review and health services/patient. The beneficiary receives his services via self determination. See Amended Hearing Summary.
- 6. The Appellant's seeks 20-hours per week of Community Living Supports to assist in implementing the behavior plan with the Appellant. (Appellant's Exhibit #1)
- 7. The Department has determined it is not medically necessary to authorize Community Living Supports (CLS) hours for this purpose. See Testimony of witnesses
- 8. The Department, at present, provides a comprehensive array of services. (Department's Exhibit A, p. 11)
- 9. The Department believes that based on information gathered from the and as reflected in the PCP and the functional analysis, respite and behavioral management review and heath services/patient education are the most efficacious means to meet the beneficiary's needs. (See Amended Hearing Summary and Department's Exhibit A, pp. 13 17)
- 10. The Appellant is enrolled in school and receives both Speech and Occupational therapies. Further development of the Appellant's IEP is pending as of this writing. (Department's Exhibit A, p. 4 and Appellant's Exhibit #1).
- 11. The Appellant was advised of the denial of CLS on (Department's Exhibit A, pp. 34 39)
- 12. The Appellant requested a formal, administrative hearing on (Appellant's 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) and 1915(c) Medicaid Managed Specialty Services waiver.

contracts with the Michigan Department of Community Health to provide mental health services pursuant to its contract 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.

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In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy, as found in the Medicaid Provider Manual (MPM), defines medical necessity.

Medical Necessity is defined as:

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.

MPM, Mental Health [ ], §1.7, p. 5, January 1, 2011

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#### **MEDICAL NECESSITY CRITERIA**

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

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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.

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#### PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

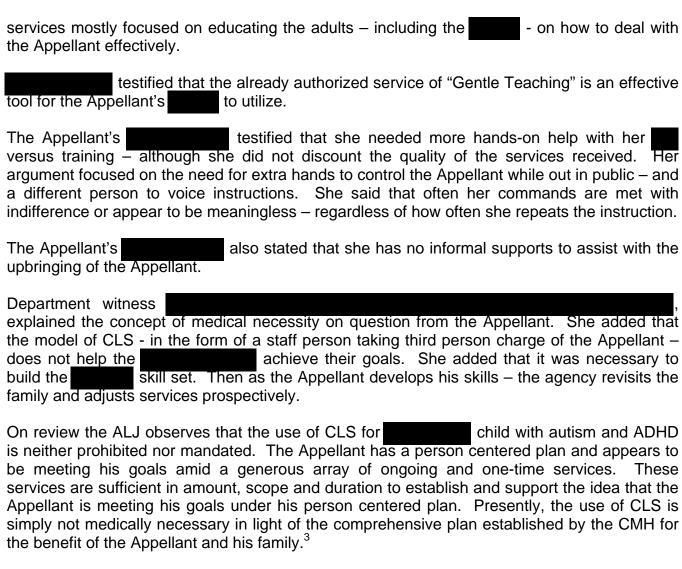
- Deny services that are:
  - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less restrictive and cost effective 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.

MPM, Supra, §§2.5 – 2.5.D, pages 13, 14.

The Department witnesses testified that the Appellant's request for CLS<sup>1</sup> was denied for lack of medical necessity. testified that she reviewed the Appellant's file, intake to and his personal care plan. She identified a wide range of services currently authorized in addition to family supports to assist the Appellant in meeting his established goals. See Department's Exhibit A, pp. 1 – 12. She added that Respite has been awarded in the amount of 6 hours per week to relieve the Appellant's She further explained that a closed grant of 55-hours of Respite was authorized on , to assist the Appellant's during/for the immediate after effects of postpartum care for her new child. She said that the current services were adequate and largely directed to the went to the family residence to conduct a functional analysis. She acknowledged that CLS could be a back-up service in the future, but added that some of the Appellant's actions were typical for and others involving community exposure would require gradual exposure and gradual increases in time. She added that the existing

<sup>&</sup>lt;sup>1</sup> A broad set of personal services available to an individual to increase or maintain self sufficiency and goal achievement in the community described in greater detail at §§15.1 and 17.3.B [Community Living Supports] of the MPM.



The Department's decision to deny 20-hours of CLS per week was appropriate when made. The Appellant has failed to preponderate his burden of proof. His representative did not provide sufficient evidence to demonstrate that the denial of CLS was in error.

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The Appellant's was advised that the PCP process is not static and will likely change as the Appellant ages. However, if there are errors, such as "no informal supports," [alleged at hearing] she needs to contact the Department to adjust the plan accordingly - whether this is new information or incorrectly recorded data.

data.

The ALJ is mindful of the fact that CLS hours were authorized in the past. This decision neither supports nor abandons any prior SOAHR decision – it is simply a different case today. It is important for the parties to remember that those prior services were provided for the Appellant's benefit by a different mental health authority, using a different person centered plan with different guardians, for an autistic child at a different, but critical, stage in his intellectual development.

#### **DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for 20-hours of CLS for lack of medical necessity.

#### IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
For Olga Dazzo, Director
Michigan Department of Community Health

cc:

Date Mailed: 3/4/2011

#### \*\*\* 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 State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filling 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.