STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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. 2011-9054 CMH
Case No. 30075796

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]. [redacted] appeared on behalf of the Appellant. Her witness was her [redacted]. [redacted], represented the Department. Her witnesses were [redacted]; [redacted] and [redacted].

The Appellant's [redacted] was present.

ISSUE

Did the Department properly deny Community Living Supports (CLS) as not 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 [redacted] Medicaid beneficiary.

2. The Appellant has been receiving services from [redacted] a CMH contractor for his medical conditions, which include ADHD, Combined and Autism. See Amended Hearing Summary.

3. 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. 3-6 and *See* Testimony).

4. The Appellant's [redacted] receives Respite and had received a closed period of additional Respite for the period following the birth of her [redacted] in [redacted]. She said she did not use the allotted hours as they were not necessary. See Testimony of [redacted].

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 [redacted] 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 [redacted].

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 [redacted] 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 [redacted] 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 [redacted]. (Department's Exhibit A, pp. 34 – 39)

12. The Appellant requested a formal, administrative hearing on [redacted]. (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.
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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) 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. [redacted] 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.
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> MPM, Mental Health [ ], §1.7, p. 5, January 1, 2011

* * *

MEDICAL NECESSITY CRITERIA

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

*** * ***

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[1] was denied for lack of medical necessity. [redacted] testified that she reviewed the Appellant's file, intake to [redacted] 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 [redacted].

She further explained that a closed grant of 55-hours of Respite was authorized on [redacted], to assist the Appellant's [redacted] 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 [redacted].

[redacted] 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 [redacted] and others involving community exposure would require gradual exposure and gradual increases in time. She added that the existing

[1] 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.

services mostly focused on educating the adults – including the [redacted] - on how to deal with the Appellant effectively.

[redacted] testified that the already authorized service of "Gentle Teaching" is an effective tool for the Appellant's [redacted] to utilize.

The Appellant's [redacted] testified that she needed more hands-on help with her [redacted] versus training – although she did not discount the quality of the services received. Her argument focused on the need for extra hands to control the Appellant while out in public – and a different person to voice instructions. She said that often her commands are met with indifference or appear to be meaningless – regardless of how often she repeats the instruction.

The Appellant's [redacted] also stated that she has no informal supports to assist with the upbringing of the Appellant.

Department witness [redacted], explained the concept of medical necessity on question from the Appellant. She added that the model of CLS - in the form of a staff person taking third person charge of the Appellant – does not help the [redacted] achieve their goals. She added that it was necessary to build the [redacted] skill set. Then as the Appellant develops his skills – the agency revisits the family and adjusts services prospectively.

On review the ALJ observes that the use of CLS for [redacted] child with autism and ADHD is neither prohibited nor mandated. The Appellant has a person centered plan and appears to be meeting his goals amid a generous array of ongoing and one-time services. These services are sufficient in amount, scope and duration to establish and support the idea that the Appellant is meeting his goals under his person centered plan. Presently, the use of CLS is simply not medically necessary in light of the comprehensive plan established by the CMH for the benefit of the Appellant and his family.[3]

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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[2] The Appellant's [redacted] 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.

[3] 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: [redacted]

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 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.