

**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

██████████
Appellant

Docket No. 2012-13291 CMH
Case No. 9179137

_____ /

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 ██████████. Appellant appeared and testified on his own behalf. ██████████, Appellant's case manager from Integro, LLC, also appeared and testified on Appellant's behalf.

██████████, Fair Hearing Officer, ██████████, Community Mental Health (CMH), represented the Department. ██████████, Utilization Manager, appeared as a witness for the Department.

ISSUE

Did CMH properly deny authorization for case management services for Appellant?

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 ██████ year-old Medicaid beneficiary with a diagnosis of 295.60 Schizophrenia Residual Type and high anxiety. (Exhibit 1, p 2)
2. Appellant resides with his girlfriend and her family. (Exhibit 1, p 2; Testimony)
3. Petitioner has been receiving case management services through Integro, LLC. (Exhibit 1, pp 11-15).
4. On ██████████ 011, ██████████, Utilization Manager for CMH, conducted a review of Appellant's file. ██████████ concluded that medical necessity for continued case management services no longer existed

because Appellant had remained stable for the past year and had met all of his treatment goals. (Exhibit 1, p 7)

5. On ██████████, CMH sent an Adequate Action Notice to the Appellant indicating his case management services were denied. The Notice included rights to a Medicaid fair hearing. (Exhibit 1, p 8).
6. The Appellant's request for hearing was received by the Michigan Administrative Hearing System on ██████████. (Exhibit 2).

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.

Medicaid beneficiaries are only 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. Medical necessity is defined by the Medicaid Provider Manual as follows:

2.5 MEDICAL NECESSITY CRITERIA

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

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.

Case Management services are also defined in the Medicaid Provider Manual:

SECTION 13 – TARGETED CASE MANAGEMENT

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.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

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.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. 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.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified

Docket No. 2012-13291 CMH
Hearing Decision & Order

	when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. 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.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

*MPM, Mental Health and Substance Abuse Section,
January 1, 2012, Pages 69-70*

[REDACTED], Utilization Manager at [REDACTED] CMH, testified that she reviewed Appellant's treatment plan, as well as the progress notes in his file, and discovered that Appellant had met all of the goals outlined therein. Specifically, [REDACTED] indicated that Appellant's met Goal #1, maintaining independence in the community, and the underlining objectives in that goal. Objective #1 called for Appellant to comply with taking his medications. Appellant's [REDACTED] progress note indicated that Appellant had been taking his medications and attending all of his mental and physical health appointments, and that no hospitalizations or crisis interventions had been reported. (Exhibit, pp 12, 16). Objective #2 called for Appellant to report 3 positive steps to assist him in managing his mental health by [REDACTED]. Again, according to Appellant's [REDACTED] progress note, Appellant accomplished this objective by speaking to his physicians regarding possible medication side effects, keeping appointments for his injections, and by attending the "Speak Up" mental health event, without assistance. (Exhibit 1, pp 12, 16). Objective #3 called for Appellant to take at least one positive step to assist himself in managing his mental health by [REDACTED]. According to Appellant's progress note dated [REDACTED], Appellant accomplished this objective by attending his injection appointments, getting out in the community and taking care of personal needs, as well as eating and sleeping well. (Exhibit 1, pp 12, 18). Objective #4 called for Appellant to maintain independence in the community and, according to a progress note dated [REDACTED], Appellant met this objective by demonstrating that he has the skills to maintain his independence in the community. (Exhibit 1, pp 12, 20).

Docket No. 2012-13291 CMH
Hearing Decision & Order

Appellant testified that he still needs case management services. Appellant indicated that he is on a new medication, Neurotin, which seems to have the side effect of making him angry and he is afraid that he could get into it with his girlfriend or her aunt and lose his present housing arrangement. Appellant indicated that he still has difficulty with completing paperwork and that, while he did attend the "Speak Up" mental health event, there were so many people there that he did not gain anything from it. Appellant indicated that he was in the process of creating new goals when he received the denial notice.

[REDACTED], Appellant's case manager at Integro, LLC, testified that, while Appellant has done well with his goals to date, they were in the process of creating new goals to help Appellant maintain what he has achieved. [REDACTED] pointed out that while Appellant does have natural supports in his girlfriend and her family, Appellant's girlfriend also has mental health issues. [REDACTED] indicated that it is very difficult for Appellant to work with new people.

[REDACTED], Fair Hearing Officer, indicated that it sounded like Appellant might need additional therapy sessions authorized so that he could deal with any potential anger issues, and that he needed to speak to his doctor regarding the side effects from the Neurotin. [REDACTED] indicated that CMH also has peer supports that can help him with paperwork and that the CMH could assign one individual to be his peer support so that Appellant would not have to deal with a lot of different people.

Based on the evidence presented, CMH did properly deny Appellant case management services. As indicated above, all services must be medically necessary, meaning those services are, "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." Additionally, "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." Here, Appellant has met all of the goals outlined in his last treatment plan and, as such, no longer needs assistance to meet those goals. The CMH also offered additional services, such as the reauthorization of therapy and peer supports, to address Appellant's concerns regarding the denial of case management services.

The burden is on the Appellant to prove by a preponderance of evidence that case management services are still medically necessary. As indicated above, Appellant did not meet his burden.

[REDACTED]
Docket No. 2012-13291 CMH
Hearing Decision & Order

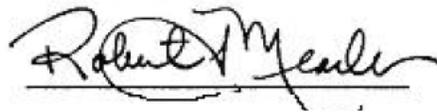
DECISION AND ORDER

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

The CMH properly denied authorization for case management services for Appellant.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.



Robert J. Meade
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 1/19/2012

***** 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.