**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.** 2012-13617 CMH
**Case No.** 85952026

Appellant
_____/

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, an in-person hearing was held [redacted]. Attorney [redacted] appeared on behalf of Appellant. Ms. [redacted], Appellant's mother appeared and testified for the Appellant. Appellant also appeared and testified in his own behalf.

[redacted], Corporate Counsel for [redacted] County Community Mental Health and Substance Abuse Services, (CMH), was present on behalf of CMH. [redacted], MA, LPC, CAADC, Access Specialist I, appeared and testified on behalf of CMH.

## ISSUE

Does the Appellant meet the medical necessity or eligibility requirements for Medicaid-covered mental health and developmental disability services through CMH?

## 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 [redacted] year-old who previously received Medicaid-covered services through CMH. (Exhibits D-G & L)

2. [redacted] County CMH is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. CMH determined that Appellant was not eligible for services in [redacted]. He did not meet the eligibility criteria as a person with a developmental disability. Following an unsuccessful appeal of CMH's decision, Appellant's services were terminated, and he was officially discharged from CMH on [redacted]. (Exhibits E, G & L).

4. On [redacted], Appellant and his mother came to CMH requesting Medicaid services. [redacted] an Access Specialist with CMH saw the Appellant and performed a screening for the requested Medicaid services. [redacted] prepared a detailed report of the screening and determined that Appellant did not meet the eligibility for any CMH services as a person with a development disability or a person with a mental illness. She further found Appellant lacked medical necessity for the requested services. (Exhibit C).

5. On [redacted], CMH sent Appellant an adequate action notice stating he was denied Case Management and Community Supports on [redacted], because he did not meet the functional impairments for services as a developmentally disabled person, and further that he did not meet the criteria as a person with a mental illness as he had no history mental health treatment and his condition was likely related to his medical condition. (Exhibit A).

6. On [redacted], MAHS received the Appellant's request for an Administrative Hearing. (Exhibit B).

## 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—

Under approval from the Center for Medicaid and Medicaid Services (CMS) the Michigan Department of Community Health (MDCH) operates a section 1915(b) waiver called the Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the MDCH to provide services under the Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. CMH must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, amended, and those services/supports included as part of the contract between the Department and CMH.

[redacted] an Access Specialist I with CMH testified she has a Master's Degree and is a licensed professional counselor with an advanced addiction counselor certification. [redacted] stated she met with Appellant in [redacted] concerning his request for services including case management and community living supports. She noted Appellant had received services in the past, but was not receiving them at the time of screening.

[redacted] identified the screening report she prepared on [redacted] regarding the Appellant. Appellant was diagnosed with a primary diagnosis of mood disorder due to his medical condition, and a medical diagnosis of grand mal epilepsy. (Exhibit C). As a result of the screening, [redacted] determined there was no change in Appellant's level of impairment since his termination from services earlier in the

year. She stated he did not meet the level of impairment to qualify for developmental disability services, and further that he did not meet eligibility for services due to a serious mental illness.

[redacted] determined Appellant had been living independently at [redacted] Apartments since [redacted]. He was not receiving any CMH or DHS services at the time of the screening. There was no concern for his living conditions, which appeared to be meeting his needs. [redacted] stated Appellant's mother had some concerns about his medications. Appellant had dexterity problems which made it hard for him to open his medications so he would leave them open and some stray tablets were found on the floor. Appellant believed he was doing just fine managing his medications.

[redacted] found no areas of concern for Appellant's self care. She determined Appellant could shower/bathe on his own, brush his teeth, change his clothes, shave and do self grooming. She noted Appellant had a payee through ROI to manage his Social Security income. Appellant was given $10 per week for pocket money. ROI pays his rent, but Appellant is given money to pay one of his utility bills. Appellant was able to pay the bill without missing a payment.

[redacted] noted Appellant's mother stated Appellant had a history of isolating behaviors and was lacking in social relations and social contact. [redacted] found Appellant mostly had social contact with his family, but Appellant had established a Facebook page to keep in contact with family and his friends from high school. Appellant indicated to her he had other things he did with his time and felt he had enough social contact. [redacted] found Appellant had used [redacted]an to get around town. Currently, Appellant's mother provides most transportation, and Appellant also gets around town by walking different places.

[redacted] stated Appellant's presentation showed no more impairment than was present at the time his developmentally disabled services were closed earlier in the year. She stated he did not meet functional impairments to qualify for developmentally disabled service criteria. [redacted] did not find that the Appellant met any of the 7 area of functional limitations listed in Exhibit G.

As for economic self-sufficiency, [redacted] stated Appellant was able to handle the money he had at his own disposal. She also acknowledged Appellant had a payee through ROI, but did not know if that was just a requirement placed on him by Social Security. [redacted]i found no problem with Appellant's expressive and receptive language. Appellant was able to respond clearly to questions without confusion, and expressed his felling clearly several times during the screening process. [redacted] found that at the time of the screening Appellant was living independently as previously indicated. Appellant was doing his own housekeeping, doing his own laundry, changing his sheets, doing general cleaning, and doing his own dishes.

As for learning disabilities, [redacted] determined that Appellant's memory was

good. He did not have any trouble remembering anything. [redacted] acknowledged that the screening process does not go in depth into learning disabilities, and there was no reading or writing involved in the screening process. It was noted in her screening report, however, that Appellant had graduated with a high school diploma from [redacted] High School.

[redacted] stated Appellant had no problems with mobility, he was fully ambulatory. Appellant was able to walk from place to place and could obtain rides from family members when needed. [redacted] stated she had no concerns with his self-care as she had previously testified. She also stated that she had no concerns with Appellant's self-direction. Appellant was satisfied with his social relationships and social contact. He was satisfied that his Facebook page gave him sufficient social contacts. Appellant was also satisfied with how he spent his time at home, such as watching TV.

[redacted] found there was a lack of medical necessity for services through CMH based on her screening of the Appellant. She was asked to reference Exhibit J concerning criteria for determining Medical Necessity. [redacted] stated she found that Appellant did not meet the eligibility criteria for developmentally disabled services and also found no medical necessity for mental health services. Appellant had no past mental health treatment and his current mental health issues were directly related to his medical condition.

[redacted] found there was no medical necessity for mental health services to treat, ameliorate or diminish Appellant's symptoms of mental illness. CMH services were not needed to arrest or delay any symptoms of mental illness or developmental disability, or to assist the Appellant in maintaining a sufficient level of functioning in society. [redacted] stated that [redacted] opinion in Exhibit F would not change her decision since the potential need for placement in an AFC home or added supervision was due to a medical condition and not due to a developmental disability or a mental health concern.

This Administrative Law Judge does not have jurisdiction to order the CMH to provide Medicaid covered services to a beneficiary who is not eligible for those services. This Administrative Law Judge determines that the Appellant is not eligible for CMH Medicaid covered services for the reasons discussed below.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6* makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual provides:

> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this

manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

| **In general, MHPs are responsible for outpatient mental health in the following situations:** | **In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:** |
|---|---|
| □ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.<br><br>□ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). <u>The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</u> | □ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).<br><br>□ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.<br><br>□ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit |

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| | maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment. |

*Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, January 1, 2012, page 3.*

The definition section contained in the Mental Health Code, specifically MCL 330.1100a(21), defines “Developmental disability” as follows:

> (21) "Developmental disability" means either of the following:
>
> (a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:
>
> (i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
>
> (ii) Is manifested before the individual is 22 years old.
>
> (iii) Is likely to continue indefinitely.
>
> (iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
>
> (A) Self-care.
>
> (B) Receptive and expressive language.
>
> (C) Learning.
>
> (D) Mobility.
>
> (E) Self-direction.
>
> (F) Capacity for independent living.
>
> (G) Economic self-sufficiency.

> (v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
>
> (b) If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Appellant's mother [redacted] testified Appellant was possibly brain damaged at birth. He was in special education in grade school and had received speech, occupational, and physical therapy in the past. Appellant went to regular high school, but was in the resource room. Appellant's mother stated Appellant has had seizures since he was [redacted] years old.

[redacted] stated Appellant was qualified for Social Security Disability payments, and Social Security required him to have a payee to manage his benefit payments. [redacted] had concerns in the past that Appellant did not know what was safe; giving examples that he had started a fire in the house, and had burned his father's shotgun. She also spoke of finding some of his medications on the floor at her house.

[redacted] stated she believes Appellant needs services such as a way to get to the doctor, and someone to go with him to the doctors. She does not believe Appellant can handle his money. She also does not believe he has the ability to learn.

[redacted] testified that since the screening Appellant's seizure activity has dramatically increased. Appellant often calls her and she has to instruct him to go to the hospital. [redacted] does not think it is safe for Appellant to live alone anymore. She believes he should be in an AFC home where there is someone around all the time to monitor him. [redacted] acknowledged that she had not verbalized these concerns to CMH.

Appellant testified he was asking for help from CMH. Appellant testified he does not feel save now in his own home. He stated there is no one around when he has a seizure. Appellant acknowledged that he did not tell the screener this back in [redacted].

In this case, the CMH screener applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid-covered mental health and developmentally disabled services, and properly determined he was not. [redacted] did not find that the Appellant had substantial functional limitations in any of areas of major life activity set forth in definition of "developmental disability" set forth in the Mental Health Code. Further, she did not find that he had a serious mental illness, or any severe symptoms of a mental illness, or any substantial impairment in his ability to perform daily living activities.

The Appellant and his mother indicated during the hearing that the Appellant was having an increase in his seizure activity since the screening was done in [redacted]. There

was also a suggestion that new medical records existed that were not available at the time of the screening. However, such new or additional information cannot be considered, only what was available to CMH at the time they denied services.

The Appellant bears the burden of proving by a preponderance of the evidence that the information reviewed by the CMH at the time of the screening established his eligibility for mental health or developmentally disabled services through CMH in accordance with the Code of Federal Regulations (CFR). The Appellant did not meet the burden of establishing his eligibility. This Administrative Law Judge is limited to the evidence the CMH had at the time it made its decision. The Appellant has not shown on this record that the information available to the CMH demonstrated eligibility for mental health or developmentally disabled services. Accordingly, CMH acted properly in denying Appellant case management and community living supports services.

## DECISION AND ORDER

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

The CMH properly determined that the Appellant does not meet the medical necessity or eligibility requirements for Medicaid-covered mental health and developmental disability services through CMH.

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: 2/6/2012

***** NOTICE *****

The Michigan Administrative Hearing System 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 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 rehearingdecision.