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],

Appellant

_____/

Docket No. 2012-21486 CMH
Case No. 3549723

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 Wednesday, [redacted]. [redacted], Appellant's mother, appeared and testified on behalf of Appellant.

[redacted], Customer Services Representative Specialist and Fair Hearings Officer for [redacted], represented the CMH. Dr. [redacted] M.D., a staff psychiatrist in the Physicians Unit Services for [redacted] appeared as a witness for the CMH.

ISSUE

Did the CMH properly terminate Appellant's psychiatric services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] County Medicaid beneficiary eligible to receive services through [redacted], the Community Mental Health (CMH) Agency serving [redacted] and [redacted] Counties.

2. CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

3. Appellant was receiving psychiatric services through CMH and [redacted] services through Highfield. (Exhibit 4 and testimony).

4. The Appellant currently resides at home with his mother, his mother's boyfriend, and his [redacted] year-old half brother. (Exhibit 1).

5. Appellant is a [redacted] year-old (DOB [redacted]) Medicaid beneficiary. On [redacted], Dr. [redacted] diagnosed Appellant with PTSD, mood disorder NOS, rule out developmental learning problems, rule out borderline intellectual functioning, and specific family circumstances. Dr. [redacted] recommended hospitalization for Appellant's depression and for him to be restarted on the Remeron. Appellant's mother did not agree and wanted a second opinion. An appointment for a second opinion was scheduled with Dr. [redacted] for [redacted]. (Exhibit 4).

6. On [redacted], Dr. [redacted] again saw Appellant and his mother along with [redacted] the [redacted] worker/coordinator from [redacted]. Dr. [redacted] was surprised to see them as the mother was upset with the previous recommendation, and had not followed through with the second opinion with Dr. [redacted]. Appellant was doing very well, he was sleeping well, had a bright affect, and he did not have symptoms of depression at that time. In Dr. [redacted] professional medical opinion Appellant did not need hospitalization or any medications at that time. Appellant's discharge diagnosis was specific family circumstances, rule out borderline intellectual functioning, and rule out developmental learning problems. Dr. [redacted] then closed Appellant's case terminating the psychiatric services. (Exhibit 4 and testimony).

7. On, [redacted], the CMH sent an advance action notice dated [redacted] to the Appellant's mother stating that Appellant's psychiatric services through the Physicians Unit Services would be terminated effective [redacted], as there was no need for psychotropic medication at that time. (Exhibit 2 and testimony).

8. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 3).

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) 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 and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations 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.*

CMH witness [redacted] testified she was [redacted] Customer Services Representative Specialist and Fair Hearings Officer. [redacted] stated Appellant was a [redacted] year-old who was Medicaid eligible and was receiving psychiatric services through CMH and

Wraparound services through [redacted]. [redacted] offered Exhibits 1-5 on behalf of CMH. She stated an advance action notice was sent out in this case on [redacted] that Appellant's psychiatric services would be terminated with the Physicians Unit Services as it was determined he had no need for psychotropic medications.

Dr. [redacted] M.D. stated she was a staff psychiatrist in the Physicians Unit Services for [redacted] and she has been a psychiatrist for over 20 years. Dr. [redacted] stated she saw Appellant on [redacted]. Appellant was very depressed at that time and told Dr. [redacted] he had thoughts of suicide. She diagnosed him with PTSD, mood disorder NOS, rule out developmental learning problems, rule out borderline intellectual functioning, specific family circumstances.

Dr. [redacted] stated she advised Appellant's mother that he should be hospitalized for his depression, there was a risk of suicide, and she did not believe he had enough supervision at home to be treated as an outpatient. Appellant's mother did not agree and wanted a second opinion. An appointment for a second opinion was scheduled with Dr. [redacted] for [redacted]. Dr [redacted] stated Appellant's mother did not keep the appointment with Dr. Alavi for the second opinion.

Dr. [redacted] stated on [redacted], she again saw Appellant and his mother along with [redacted] the [redacted] worker/coordinator from Highfield. Dr. [redacted] was surprised to see them as the mother was upset with the previous recommendation, and had not followed through with the second opinion with Dr. [redacted].

Appellant was doing very well at that time, he was sleeping well, had a bright affect, and he did not have symptoms of depression at that time. In Dr. [redacted]s professional medical opinion Appellant did not need hospitalization or any medications at that time. Appellant's discharge diagnosis was specific family circumstances, rule out borderline intellectual functioning, and rule out developmental learning problems. Dr. [redacted] stated she then closed Appellant's case terminating his psychiatric services. Dr. [redacted] stated that in the future if the Appellant's condition warranted it, the case could be reopened and he could again receive psychiatric services through CMH.

The *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section dated January 1, 2012*. 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, January 1, 2012, 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.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, January 1, 2012, pp. 12-13.

Appellant's mother testified Appellant is extremely depressed and angry and she wants him on medication. She stated he is very negative and something needs to be done. [redacted] stated he see's a sexual counselor and the counselor agrees there are depression issues. [redacted] cannot understand how Dr. [redacted]'s opinions from one time to the next can be so different. She wants Appellant hospitalized or in outpatient therapy with medications.

CMH must base its denial or termination of mental health services on medical necessity. In this case, CMH presented sufficient evidence to show it based its decision to terminate services on medical necessity. Dr. [redacted] CMH's staff psychiatrist saw the Appellant on two separate occasions. At the first visit Appellant was displaying symptoms of depression such that Dr. [redacted] felt that hospitalization was necessary due to Appellant's thoughts of suicide. However, the Appellant's mother did not agree she wanted a second opinion. Several weeks later Dr. [redacted] saw Appellant and surprisingly he was doing very well. Appellant was sleeping well, he had a bright affect, and he did not display symptoms of depression at that time. In Dr. [redacted]'s professional medical opinion Appellant did not need hospitalization or any medications at that time. Appellant's discharge diagnosis was specific family circumstances, rule out borderline intellectual functioning, and rule out developmental learning problems. Accordingly, Dr. [redacted] closed Appellant's case and terminated his psychiatric services.

This administrative law judge is limited to the evidence CMH had at the time it made its decision. The Appellant bears the burden of proving by a preponderance of the evidence that the psychiatric services requested are medically necessary. Applying the evidence the CMH had at the time it made its decision in [redacted] to the relevant Medicaid policy supports the CMH position that the psychiatric services are not medically necessary.

Appellant's mother's disagreement with Dr. [redacted] does not outweigh the professional opinion of a trained psychiatrist that the Appellant was not in need of hospitalization or psychotropic medications at the time she closed the Appellant's case and terminated his psychiatric services. The Appellant did not meet his burden of establishing medical necessity for psychiatric services that were determined to not be medically necessary by CMH in accordance to Medicaid policy and the Code of Federal Regulations (CFR).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly terminated Appellant's psychiatric services.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 2/3/2012

***** 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.