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. 2012-47299 CMH
Case No. [redacted]

_____/

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] Appellant appeared and testified on her own behalf. [redacted], Appellant's Case Manager, and [redacted] Appellant's [redacted], also appeared and testified on Appellant's behalf.

Attorney [redacted], Corporate Counsel for Kalamazoo County Community Mental Health and Substance Abuse Services (CMH or Department), represented the Department. [redacted] Utilization Review Coordinator; [redacted] Customer Service Manager; and [redacted] Customer Services Specialist, appeared as witnesses for the Department.

ISSUE

Did CMH properly terminate 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 [redacted] Medicaid beneficiary with mental health diagnoses of Schizophrenia and Depression. Appellant's medical diagnoses include Diabetes Type II, HTN, Hypothyroidism, Coronary Artery Disease S/P Stents [redacted] Dyslipidemia, Cataracts, Sciatica, GERD S/P Bilateral Oophrectomy [redacted]

2. Appellant is prescribed the medications [redacted]

3. Appellant resides in her own apartment, she schedules and attends her

own doctor appointments and she has a car and drives. Appellant has [redacted] live locally and the other visits from [redacted] at least annually. One of Appellant's s[redacted] is her trustee for a trust that includes one half of Appellant's [redacted]. Appellant also has [redacted], one of whom who is closely involved in her [redacted]

4. Appellant has been receiving various mental health services for [redacted] She was psychiatrically hospitalized in [redacted]. Appellant has received case management services from [redacted]

5. Beginning on [redacted], Utilization Review Coordinator for CMH, conducted a utilization review of Appellant's services. [redacted] concluded that medical necessity for continued case management services no longer existed because Appellant had remained stable in the community since [redacted] with minimal linking and coordinating by her case manager. [redacted]

6. On [redacted] CMH sent an Adequate Action Notice to the Appellant indicating that her case management services were being terminated. The Notice included rights to a Medicaid fair hearing. [redacted]

7. The Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]

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. Lifeways 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.

2.5.D. 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, Mental Health and Substance Abuse Section, January 1, 2012, Pages 12-14

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 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 Review Coordinator for CMH testified that she began a utilization management review of Appellant's services on [redacted]. [redacted] explained that the purpose of the utilization management review is to take a look at the services a person is receiving in an objective manner to determine if all authorized services are still medically necessary. [redacted] testified that her review demonstrated that Appellant was independent and required no help with transportation in the community, personal care, community living, medication, living arrangements, communication or challenging behaviors, but that Appellant occasionally required household assistance. [redacted] explained that Appellant resides in her own apartment, has extensive family support, including [redacted] who live locally and a [redacted] that Appellant makes and attends her own medical appointments, and that Appellant has her own car and drives. [redacted] also testified that Appellant is stable psychiatrically and has not been hospitalized psychiatrically since [redacted] concluded that Appellant has been stable in the community since [redacted] with minimal linking and coordinating by her case manager. [redacted] pointed out that while Appellant does have a number of ongoing concerns and stressors such as medical problems, aging, family stressors and a bedbug infestation, it would be more appropriate for Appellant to process those concerns with an outpatient therapist as opposed to a case manager. [redacted] testified that she would recommend terminating Appellant's case management services as not medically necessary, adding outpatient therapy services, and maintaining Appellant's psychiatric services.

Appellant testified that she still needs case management services. Appellant indicated that she gets overwhelmed and confused by all of her medical conditions and appointments and that her case manager helps her to straighten things out. Appellant also testified that her case manager can intervene on her behalf with regard to doctors and appointments while an outpatient therapist would not be able to so intervene. Appellant likened her case manager to having a wise parent who could intervene on her behalf when she becomes troubled.

[redacted] Appellant's Case Manager, testified that she supports Appellant's request to maintain her case management services. [redacted] testified that she does help Appellant process her weekly schedule but does not accompany Appellant to any of her appointments. [redacted] also pointed out that while Appellant does have significant family support, there exists some conflict between her [redacted] that could be exacerbated should they have to take on a greater role. Finally, [redacted] requested that if Appellant's case management services are terminated that there be a period of overlap to assist with the transition.

[redacted], testified that Appellant's [redacted] cannot replace the case manager because the change would cause stress within the family and hurt Appellant's family relationships. [redacted] pointed out that Appellant gets along very well with [redacted], her current case manager, and that this has not always been the case as Appellant has had conflicts with her case managers in the past. [redacted] pointed out that with Appellant's increasing medical difficulties, it is becoming more and more difficult for her to manage all of her appointments.

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 maintained stability in the community since [redacted] with minimal linking and coordinating of services by her case manager and it appears that the offered outpatient therapy will assist Appellant with her needs in a less restrictive manner than those of case management services. It appears that Appellant was using her case manager more as a counselor or confidant than as someone who would "design and implement strategies for obtaining services and supports that are goal-oriented and individualized." While Appellant's case manager could intervene on Appellant's behalf, it does not appear from the evidence presented that Appellant's case manager did much intervening.

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.

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: 6/11/2012

***** 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.