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:

Docket No. 2012-47300 CMH

[redacted]

Appellant

_____/

DECISION AND ORDER

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

After due notice, an in-person hearing was held [redacted]. The Appellant [redacted] was present and gave testimony in his own behalf. [redacted] Appellant's Case Manager with [redacted] was present but did not testify.

Attorney [redacted], Corporation Counsel for [redacted] County Community Mental Health and Substance Abuse Services, hereinafter CMH, represented CMH. Ms. [redacted] MA, LPC, RN, MA LLP, a Utilization Review Coordinator with the Southwest Michigan Affiliation, the PIHP serving [redacted] County, appeared and testified on behalf of CMH. [redacted], LBSW, Customer Services Coordinator was also present but did not testify.

ISSUE

Did CMH properly terminate Appellant's Case Management services based upon a finding that Assertive Community Treatment (ACT) services were 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 a Medicaid beneficiary who has been a receiving case management services through [redacted] and [redacted] County Community Mental Health and Substance Abuse Services. Appellant is currently diagnosed with Schizophrenia. (Exhibits B, C, F, and 1).

2. [redacted] County Community Mental Health and Substance Abuse Services is the Community Mental Health contractor with the State of Michigan. (hereinafter

CMH)

3. On [redacted], CMH determined the Appellant's services should be stepped up to assertive community treatment (ACT services). (Exhibits A & F).

4. On [redacted], Appellant was sent an Advance Action Notice stating that effective [redacted] his case management services would be terminated and he would be referred for ACT level services. (Exhibits A & F).

5. On [redacted], MAHS received Appellant's Request for Hearing stating that he does not require ACT services at this time. (Exhibit B).

6. On [redacted] Ms. [redacted] MA, LPC, RN, a Utilization Review Coordinator conducted a Utilization Management Review. Ms. Hall recommended that Appellant's case management and CMH psychiatry services be discontinued and ACT level services with psychiatry be added. (Exhibits C & F).

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.

In CMH is denying case management services for the Appellant and has authorized instead a more restrictive level of services referred to as ACT services. The services are more intense than case management services. The Appellant has asked to continue his case management services and states he does not need ACT services at this time. CMH asserts ACT services are medically necessary for this Appellant due to his current functional and mental health status.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Assertive Community Treatment Program, Section 4* gives a description of ACT services. It states in part:

> Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. Michigan adopted a modified ACT model in the 1980's tailored to Michigan service needs. While a PIHP is free to use either the Michigan ACT model or the federal Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model, with prior Department approval, the use of the Michigan model is strongly encouraged.
>
> ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are

> individually tailored to meet the needs of the beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team.
>
> *Medicaid Provider Manual, Mental Health & Substance Abuse Services, April 1, 2012, Section 4, p. 24*

Section 4.2 identifies the target population for ACT services:

> ACT services are targeted to beneficiaries with serious mental illness, which may include personality disorders, who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.
>
> - Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication adherence.
> - Beneficiaries with serious mental illness with a co-occurring substance disorder.
> - Beneficiaries with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison.
> - Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
> - Older beneficiaries with serious mental illness with complex medical/medication conditions.
>
> *Medicaid Provider Manual, Mental Health & Substance Abuse Services, Section 4.2, p. 24*

Section 4.5 provides the ACT services eligibility criteria, with regard to diagnosis, severity of illness and intensity of service.

> **Diagnosis**
> The beneficiary must have a mental illness, as reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V Codes).
>
> **Severity of Illness**

Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance.

- Self-Care/Independent Functioning - Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations.

- Drug/Medication Conditions - Drug/medication adherence and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions.

- Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Intensity of Service
ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.

- The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment.

- The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.

- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

- Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.

- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

Medicaid Provider Manual, Mental Health & Substance Abuse Services, April 1, 2012, Section 4.5, pp. 27-29.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. 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 is required to use a person-centered planning process to identify medically necessary services and how those needs would be met pursuant to its contract with the Department of Community Health. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

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

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for the timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

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, fate-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.

Medicaid Provider Manual
Mental Health/Substance Abuse Section,
April 1, 2011 pages 12-14.

Ms. [redacted] the witness for CMH stated she was a Utilization Review Coordinator for the Southwest Michigan Affiliation which is the Prepaid Inpatient Health Plan (PIHP) covering four counties including [redacted] County. Ms. [redacted] stated she has a Master of Arts degree, she is a licensed professional counselor, and she is a registered nurse. Ms. [redacted] did a utilization management review of Appellant's case on [redacted] in response to his appeal to determine the appropriate level of services for the Appellant. (Exhibit C).

Ms. [redacted] stated earlier in [redacted] Appellant exhibited some behaviors and symptoms that had increased or escalated. This resulted in Appellant making frequent calls to his case manager and healthcare providers, primarily after hours and on weekends, expressing a need for services to deal with his anxiety and to deal with his fears and perceptions. As a result, Appellant's Case Management agency felt Appellant needed to be referred to Assertive Community Treatment (ACT). Appellant did not agree and filed his appeal.

Ms. [redacted] stated some of Appellant's calling has decreased since his appeal was filed, but other behaviors of concern that have occurred at Pathways Club House have increased. Ms. Hall stated she reviewed Appellant's primary assessment, his IPOS, progress notes from his case management file, psychiatric notes, med review notes, psychiatric evaluations and consultations with the psychiatrist, and progress notes and an incident report from the Pathways Club House. She stated her review is done primarily on the Appellant's records without interviewing the Appellant.

Ms. [redacted] noted Appellant had a history of some medication non-compliance going back to [redacted]. He had stopped taking some of his medications on his own between his appointments without his doctor ordering it, over concerns he was being poisoned or being over medicated. Appellant was displaying poor judgment and impulse control generating an excessive number of calls over the weekends to various healthcare providers. Appellant also had made some veiled threats of violence to an individual at Club House on [redacted]

[redacted]. Appellant also exhibited disruptive behaviors in [redacted] including disruptive behaviors at Club House, making excessive calls to his case manager and healthcare providers, and telling PathWays clients that staff was being fired.

Ms. [redacted] stated they believe Appellant lacks insight into his own condition as they believe he needs a higher level of treatment and he does not, and the doctors have made medication changes that the Appellant does not agree with. Appellant has had increased appointments more than what is expected for someone on case management level of services. Starting in [redacted], Appellant started making an excessive number of phone calls, and his problem behaviors at Club House occurred primarily in [redacted]

Ms. [redacted] stated Case Management and Psychiatry worked to stabilize the Appellant before they made their recommendation that he be referred to a higher level of services available through ACT services. Ms. [redacted] concluded, as evidenced by Appellant's excessive demands for CMH services, and his increased negative behaviors in the community, that the Appellant's needs were not being effectively met by case management services. Ms. [redacted] stated the Appellant's demonstrated need for after hours and weekend services shows he needs the higher level of services available through ACT services.

Applying the Medical necessity criteria in the Medicaid Provider Manual, (See Exhibit D), Ms. [redacted] concluded that ACT Services were medically necessary. She further determined that the PIHP was justified in terminating Case Management services in [redacted] according to Medicaid policy, as they had proven to be ineffective for the Appellant at that time. Ms. [redacted] opined that ACT services were medically necessary, but believed they might only be needed short term if the Appellant could demonstrate a [redacted] months period of stability. At that time, he could again be stepped down to case management services.

The Appellant testified he was healthy and did not believe he needed Act level services. He stated his current diagnosis is Schizophrenia. Appellant indicated he was better with case management services than when he was on ACT level services. Appellant asserted that his medication changes caused his unusual behaviors, and he believes he was overdosed on Latuda, which he said was documented at [redacted].

Appellant stated he is better now than he was in [redacted] He is not 100% but is improving. Appellant stated he was advocating for himself and feels the BridgeWays director and his doctor took his criticism in a negative way. Appellant stated he believed things could be worked out and he wants to continue with his current case manager and his current doctor. Appellant believes he has made leaps and bounds since starting his current medications. (See Exhibit 1).

The credible and persuasive evidence of record demonstrates that the Appellant's functional status is such that more intensive services are medically necessary at this time. As correctly pointed out by Ms. [redacted] Appellant's excessive demands for CMH services and his negative behaviors in the community demonstrate that ACT Services are medically necessary, and that continuing Case Management services would not be appropriate at this time.

Appellant's request for case management services and his functional status are incongruent. CMH has presented sufficient evidence to establish that the Appellant does meet the ACT criteria set forth in policy. Reviewing the intensity of services provided as ACT services it is apparent the Appellant does require the intense level of services described. CMH properly concluded that Case Management services would be ineffective at this time. Accordingly, this ALJ concurs with the Department's determination that the Appellant does require ACT services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly terminated Appellant's Case Management services based upon a finding that Assertive Community Treatment (ACT) services were medically necessary.

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: 6-4-12

***** 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.