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. 2012-5581 CMH
Case No. 12078839

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, a telephone hearing was held [redacted]. [redacted], Appellant appeared and testified in her own behalf.

[redacted], Director of Customer Services and Recipient Rights for [redacted] (CMH), represented the Department. [redacted] Utilization Manager for LifeWays appeared as witnesses for the CMH.

ISSUE

Does the Appellant meet the medical necessity or eligibility requirements for Medicaid Specialty Supports and 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 (DOB [redacted]) who was receiving Medicaid covered Specialty Mental Health Services through the CMH. Appellant also has Medicare insurance. (Exhibit 1, Attachment C).

2. CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.

3. CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.

4. Appellant was diagnosed with depressive disorder, NOS, alcohol dependence in full remission, and borderline personality disorder with dependent traits. (Exhibit 1, Attachment B).

5. On [redacted], [redacted], a Utilization Manager with [redacted] completed a special review of the Appellant's mental health treatment. [redacted] authored a treatment denial after determining that the Appellant no longer met the medical necessity for mental health treatment through the CMH, and further that she no longer qualified to receive services from CMH as the Appellant's symptoms were not causing a significant impairment in functioning. (Exhibit 1, Attachment A & C).

6. On [redacted], CMH sent Appellant an adequate action notice that Appellant did not qualify for the mental health services requested based upon her benefits, diagnosis and symptoms. Further, that the services requested are not medically necessary and the intensity of the services is not supported by the clinical records. Her request for mental health services was denied effective [redacted] The notice informed Appellant of her right to a fair hearing. (Exhibit 1, Attachment D).

7. On [redacted], MAHS received the Appellant's request for an Administrative Hearing. (Exhibit 1, Attachment E).

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.

CMH witness [redacted] testified she reviewed the Appellant's file when they reached the normal review point. [redacted] stated she did not find medical necessity for continued outpatient therapy through the CMH. She stated the Appellant had learned a great number of skills from her therapy sessions, and was gaining insight into how she contributes to and increases conflicts in relationships. [redacted] stated Appellant has learned ways to change her behavior to avoid conflicts with her boyfriend, such as, walking away and taking a time out and reducing her own negative responses.

[redacted] stated based on her review of the clinical records she did not see that the Appellant's symptoms were prohibiting her from functioning in multiple areas. She was getting out into the community, she reported things were a little better with her boyfriend, and she appeared to be fairly stable. [redacted] also pointed out that Appellant's psychiatric notes indicated Appellant was alert, oriented times 3, was appropriately dressed, had good eye contact, and had an appropriate affect. The notes stated Appellant was slightly depressed, but there was no homicidal or suicidal ideation, no cutting, no hallucinations or delusions, and she was goal directed in her speech.

[redacted] concluded that the Appellant was not suffering any symptomatology regression and was functioning fairly adequately. She stated the Appellant became eligible for specialty mental health services through the CMH because she was experiencing a significant depression, anxiety, and anger outbursts. However, over the course of treatment, Appellant had gained the skills to learn how to cope with those symptoms to the point that they were no longer significantly interfering with her ability to function adequately in society. [redacted] concluded that there is no longer a medical necessity for the specialty mental health treatments through the CMH, and that she no longer qualifies due to her diagnosis for these services.

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	□ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally

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. ☐ 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>	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). ☐ 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. ☐ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit 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, October 1, 2011, page 3.

Appellant testified she has battled depression and has been suicidal since she was [redacted] years old. She stated she was sexually abused when she was a baby. Appellant realized this as an adult and has had trouble dealing with men. Some days she is fine and other days she just doesn't know what to do. Appellant stated she finally decided to go for help, and now this help has been taken away because she has learned some coping skills.

Appellant stated she has some problems that are deep rooted. She stated she was very depressed and hadn't taken a shower since Thanksgiving. She has been chewing her finger nails down and has lost 13 pounds. Appellant stated she pushed herself to come to the hearing and keeps trying every day. Appellant stated she did not get a volunteer job because she ran away from the background check due to her past DWIs. She has had nothing to drink for 6 years and goes to church on occasion. She also has a friend, but is not able to see her often.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid Covered mental health services and properly determined she was not. Appellant's clinical records that were reviewed by the CMH demonstrated the Appellant has no significant symptoms that are interfering with her ability to function. Appellant's clinical records do not establish medical necessity for continuing the services requested.

Appellant's current diagnosis and the related symptoms indicate that at the time of the review the Appellant no longer met the qualifications for continuing the specialty mental health services through the CMH. However, Appellant is not without assistance for her mental health issues as she can still continue individual therapy and may obtain psychiatric services using her Medicare insurance coverage. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH.

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 eligibility requirements for Medicaid Specialty Supports and 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: 12/6/2011

***** 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.