STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS SYSTEM
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IN THE MATTER OF

Docket No. 2012-5582 CMH
Case No. 5425715

[redacted],
Appellant

_____/

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]. [redacted], a Certified Peer Support Specialist with [redacted], appeared and testified on behalf of Appellant. Appellant [redacted] appeared and testified in her own behalf.

[redacted] represented the Department's agent [redacted] County Community Mental Health and Substance Abuse Services (CMH). [redacted], MA LPC RN, a Utilization Review Coordinator, and [redacted], LBSW, Customer Services Coordinator, appeared and testified on behalf of the CMH.

ISSUE

Did CMH properly terminate Appellant's case management, psychiatric services, and payment for her representative payee?

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 was a [redacted] year-old Medicaid beneficiary (DOB [redacted]) at the time of the hearing.

2. The Appellant has been receiving mental health services through CMH, including case management services, community living supports, nursing/medication review and payee/conservator services. (Exhibit B and testimony).

3. CMH determined that Appellant's services should be terminated and sent Appellant an action notice on [redacted]. (Exhibit A).

4. Appellant requested a local appeal, and [redacted], a Utilization Review

Coordinator, conducted a Utilization Management Review of Appellant's case on [redacted]. [redacted] recommended that Appellant's mental health services be terminated. [redacted] stated that medical necessity was not found for continuing these services. (Exhibit B).

5. On [redacted], [redacted] sent Appellant an Appeal Disposition letter. The letter stated the CMH was upholding the decision to terminate her case management services, her psychiatric services, and payment for her representative payee. The letter informed Appellant of her rights to a fair hearing. (Exhibit A).

6. The Appellant's request for hearing was received on [redacted]. (Exhibit C).

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.
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> *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.

The Respondent's witness, [redacted] testified she did a Utilization Management Review of Appellant's case on [redacted] after a routine quarterly quality management review indicated medical necessity was not found for continuation of Appellant's mental health services through CMH. [redacted] determined Appellant's Case Management services including her psychiatric services at InterAct should be terminated.

[redacted] stated Appellant's clinical records showed she was independent in her activities of daily living. [redacted] stated Appellant was her own guardian, but did have payee services through InterAct. She stated Appellant had not completed Dialectic Behavior Therapy (DBT). [redacted] stated Appellant collects Social Security Disability, she has a Medicaid Spend-down that she must meet, and she receives Medicare.

[redacted] stated Appellant has some financial support from her father, and did have some informal support from friends. Appellant was relatively stable and had not been hospitalized since [redacted]. [redacted] stated the Appellant had revoked her release for coordinating with her primary care physician in [redacted] and stated she was receiving her psychotropic medications from her primary care physician. As of the date of [redacted] review, Appellant had not engaged in planning for a new person centered plan.

[redacted] concluded the Appellant's services should be terminated. Her rationale for this determination was that medical necessity was not found for a continuation of Appellant's case management services. Appellant had demonstrated she was able to coordinate services on her own, as evidenced in part by the fact that she had revoked the release for them to coordinate her care with her primary care physician. Appellant had demonstrated she did not need the linking and coordinating services that were being provided by InterAct, and accordingly she also could not continue to receive psychiatric services through InterAct.

[redacted] further stated Appellant was receiving her psychotropic medications from her primary care physician and no longer needed medication review services. [redacted] stated according to policy contained in the Medicaid Provider Manual there must be a showing of medical necessity for a continuation of these services. A PIHP can deny services where there are other appropriate, efficacious, less-restrictive and cost-effective services, settings or supports that otherwise satisfy the standards for medically-necessary services.

[redacted] pointed out that in this case the Appellant had demonstrated she no longer needed the linking and coordinating services provided by case management services. Furthermore, her medical needs were being met by her primary care physician. Finally she could continue receiving outpatient mental health services through the CMH if she so desired.

[redacted] testified that as the [redacted] Michigan Alliance, they were the PIHP (Prepaid Inpatient Health Plan) for [redacted] County. [redacted] stated she sent Appellant the Appeal Disposition letter advising her that the termination of services was upheld by their review. Appellant was advised she could still receive DBT through CMH as an outpatient therapy if she wanted to receive this service. [redacted] further advised Appellant CMH services could not be continued as a way to meet her Medicaid Spend-down.

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.*

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.
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> *Medicaid Provider Manual*
> *Mental Health /Substance Abuse*
> *Version date 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.

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
Version date January 1, 2012 pages 12-14.

Appellant testified she believes she needs case management services. Appellant stated she does not have enough natural supports. She submitted a letter from her only friend and main source of support, [redacted], asking that Appellant's services through InterAct be continued. (Exhibit F). Appellant stated she became depressed over losing her case management services. Appellant stated she has no means of outside social contact without these services. She is afraid of becoming suicidal without these services and believes she needs them to remain stable. Appellant stated just because she can make her own medical appointments does not mean she doesn't meet the medical necessity for case management services.

[redacted], Appellant's representative testified he reviewed Appellant's clinical records for the past two years. (See Exhibits H-J). He expressed concerns about her continued stability. He stated the Appellant has not been relying on her current case manager for anything except issues concerning insurance and payee services. Appellant was relying on a peer support specialist for assistance with her other primary concerns. [redacted] stated Appellant has been able to carefully keep track of her Medicaid Spend-down and could set up appointments which would take care of the Spend-down.

[redacted] indicated the Appellant does not know what her diagnosis of borderline personality disorder means and does not know how to deal with it. [redacted] urged that Appellant's case management services should be continued until she learns to deal with her borderline personality disorder. He felt the Appellant needed the frequent contacts provided by her case management services in order to remain stable, which would include going to classes and continuing her recovery.

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. The Appellant had clearly demonstrated she could coordinate her own services and no longer needed the linking and coordinating services provided by case management services. Accordingly, case management services were no longer medically necessary. Appellant could continue with outpatient therapy through the CMH if she wished, and her other medical services could be covered by Medicare.

The Appellant must prove by a preponderance of evidence that the CMH denial of mental health services was not proper. However, the Appellant's proofs did not establish by a preponderance of the evidence that a continuation of case management services was medically necessary. As indicated by policy the PIHP could properly deny services where there exists other appropriate, efficacious, less-restrictive and cost-effective services, settings or supports that otherwise satisfy the standards for medically-necessary services. It is noted that this Decision and Order does not

preclude the Appellant from requesting other mental health services from CMH in the future if she believes they are medically necessary.

DECISION AND ORDER

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

The CMH 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: 1/6/2012

***** NOTICE *****

The Michigan Administrative Hearings 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 Hearings 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.