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. 2012-58572 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.

Attorney [redacted] Corporate Counsel for Kalamazoo County Community Mental Health and Substance Abuse Services represented the Department (CMH or Department). [redacted] S upervisor, Substance Abuse Services; [redacted] Customer Service Manager; and [redacted] Re cipients Rights Officer, appeared as witnesses for the Department.

ISSUE

Did CMH properly terminat e outpatient substanc e abuse services for Appellant?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] old Medicaid beneficiary. (Exhibit 2, p 2)

2. Appellant was receiv ing substanc e abuse s ervices in t he form of one-on-one individual therapy through CMH. (Exhibit 1, pp 8-19)

3. On [redacted] Appellant 's t herapist closed her case becaus e Appellant had not partici pated in any therapy se ssions since [redacted] (Exhibit 1, pp 5-7; Testimony)

4. On [redacted] CMH sent an Adequate Action Notice to the Appellant indicating that her substance abuse services were being terminated. The Notice included rights to a Medicaid fair hearing. (Exhibit 1, pp 5-7).

5. The Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted] (Exhibit 2).

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.

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

Substance Abuse services are also defined in the Medicaid Provider Manual:

SECTION 12 – SUBSTANCE ABUSE SERVICES

12.1 COVERED SERVICES - OUTPATIENT CARE

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services. Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination. Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.

[redacted] Supervisor, Substance Abuse Services for CMH, testified that Appellant's therapist closed her case because Appellant missed 8 out of 10 therapy appointments in the first part of [redacted]. [redacted] testified that after the CMH sent Appellant an Adequate Action Notice informing her that her services were being terminated, CMH offered to conduct a new assessment to see if Appellant qualified for any further services. An appointment was scheduled for [redacted], but Appellant called the CMH prior to the appointment and cancelled it. The appointment has now been scheduled for the week of [redacted]

Appellant testified that she stopped attending therapy because she thought she could move on without it, but has since realized that she still needs therapy. Appellant indicated that she knew it was wrong to miss so many appointments, but that she always called ahead of time to cancel her appointments so that the appointment slots could be used by other participants. Appellant testified that it would be helpful if she could at least continue individual therapy once per month. Appellant indicated that she is all alone and has no-one else to talk to.

Based on the evidence presented, CMH properly terminated Appellant's substance abuse services as not medically necessary because of Appellant's failure to utilize the services. As indicated above in Section 2. 5.D of the Medicaid Provider Manual, the CMH may deny services that are deemed ineffective based on accepted standards of care. CMH may also limit or terminate services pursuant to 42 CFR 440.230(d) based on criteria such as medical necessity and utilization of services. Here, Appellant was not effectively utilizing the services provided to her when she missed 8 out of 10 individual therapy appointments. Appellant was encouraged to attend the screening session set for the week of [redacted] to see if she is eligible for any services. Appellant was also provided information about outside service providers that may be able to help her.

The burden is on the Appellant to prove by a preponderance of evidence that substance abuse services are still medically necessary. As indicated above, Appellant did not meet her 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 substance abuse 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: 8/30/2012

***** 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.