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. 2012-9352 CMH
Case No. 14176525

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 on [redacted]. Appellant [redacted] appeared and testified on his own behalf.

Ms. [redacted], Due Process Manager for [redacted] County Community Mental Health, represented and gave testimony for the Department (CMH or Department). Ms. [redacted], RN, BSN, a Utilization Management Coordinator for CMH's Utilization Management Department, also appeared as a witness for the Department.

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 Medicaid Beneficiary, born [redacted], who was screened for services at CMH on [redacted]. (Exhibit 1, pp 1-13). Appellant is also enrolled in a Medicaid Health Plan (MPH), Health Plus Partners. (Exhibit 1).

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 is diagnosed with Mood Disorder, NOS; Opiod Dependence; and Dependent Personality Disorder. (Exhibit 1, p 6). At the hearing, Appellant introduced a letter from therapist [redacted], MS, TLLP, QMHP, which indicates that Appellant's diagnoses are: Bi-Polar Disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Panic Disorder with Agoraphobia, Kleptomania, Polysubstance Dependence and Social Phobia, Other Type (water). (Exhibit 3). However, CMH did not have this information when it conducted its screening of Appellant on [redacted].

5. On [redacted], Appellant underwent a telephone Access Screening through CMH, conducted by Catherine Casetta, RN. (Exhibit 1, pp 1-13).

6. On [redacted], [redacted], a Utilization Management Coordinator for CMH's Utilization Management Department, completed an audit or eligibility review of the Appellant's screening. Ms. [redacted] determined that the Appellant did not meet the eligibility criteria for services through CMH as a person with a serious mental illness or a developmental disability. (Exhibit 1, pp 17-23).

7. On [redacted], CMH sent the Appellant written notice that he did not meet the eligibility criteria for services through CMH. The notice informed Appellant of his right to a fair hearing. (Exhibit 1, pp 14-17).

8. On [redacted], MAHS received the Appellant's request for an Administrative Hearing. (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—

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.

Ms. [redacted], an RN, BSN with CMH, testified that she completed an audit or eligibility review of Appellant's Access Screening on [redacted]. (Exhibit 1, pp 17-23). Ms. [redacted] stated she found the Appellant did not meet any of the criteria for eligibility for CMH services as an adult with a serious mental illness and there was nothing to indicate a developmental disability. Ms. [redacted] indicated that there were no diagnoses for Appellant in the Department's system, but that the Access Department screener assigned Rule Out diagnoses of Mood Disorder NOS, Opiod Dependence, and Dependent Personality Disorder. (Exhibit 1, p 17).

Ms. [redacted] stated Appellant did not present with medical necessity for the case management services he requested because Appellant had no prior Psychiatric Evaluations in the Department's system or any prior psycho social assessments on record. Ms. [redacted] noted that Appellant has had three Access Screenings in the past year and all found that Appellant did not meet medical necessity for services and that Appellant's mental health treatment history was limited to attending therapy at Consumer Services, with no reported hospitalizations or other high end service use. Ms. [redacted] stated Appellant has a Medicaid Health Plan (MHP), Health Plus Partners, which would cover Appellant's ongoing outpatient mental health services, as well as ongoing medication and psychiatric services. Ms. [redacted] noted that other issues reported by Appellant were matters that could be addressed through outpatient therapy and medications or medication reviews which are covered benefits under his MHP.

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	**In general, PIHPs/CMHSPs are**

outpatient mental health in the following situations:	**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 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). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	☐ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally 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.

The definition section contained in the Mental Health Code, specifically MCL 330.1100d(3), defines "Serious Mental Illness" as follows:

> (3) "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:
>
> (a) A substance abuse disorder.
>
> (b) A developmental disorder.
>
> (c) A "V" code in the diagnostic and statistical manual of mental disorders.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Targeted Case Management, Section 13* describes Targeted case management and the various services that may be included. This section of the manual states in part:

> **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.

Section 13.3 Core Requirements also sets forth additional requirements for the provision of case management services. These requirements include: 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; the plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs); 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; and, targeted case management shall not duplicate services that are the responsibility of another program.

Medicaid Provider Manual, Mental Health and Substance Abuse, Targeted Case Management, Section 13, July 1, 2011, pp. 67-68.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, Section 2.5* lists the criteria the CMH must apply before Medicaid can pay for outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

> **2.5.B. DETERMINATION CRITERIA**
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> 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/aides) who know the beneficiary; and
> - Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
> - For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized 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.
> - Documented in the individual plan of service.

Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Section, October 1, 2011, p. 13.

Appellant testified that he has additional diagnoses that the screener did not identify, including Bi-Polar Disorder, Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Panic Disorder with Agoraphobia, Kleptomania, Polysubstance Dependence and Social Phobia, Other Type (water). (Exhibit 3). Appellant testified that he has a hard time keeping schedules straight and a hard time remembering to take his medications. Appellant also indicated that he has a number of

physical health problems, such as IBS, GERD, and bladder problems, that also affect his mental health. Appellant indicated that he is unemployable and not seeking to further his education. Appellant testified that he has no real natural supports and that if he cannot stay with friends, he goes to a shelter. Appellant confirmed that he is currently receiving substance abuse treatment, which includes methadone treatment and medical reviews.

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 he is not. Appellant's diagnoses known to CMH when it conducted Appellant's screening and audit are not qualifying diagnoses for Medicaid eligibility as a person with a severe mental illness. As Ms. [redacted] noted, Appellant's mental health treatment history is limited to attending therapy at Consumer Services, with no reported hospitalizations or other high end service use. Ms. [redacted] also correctly pointed out that other issues reported by Appellant were matters that could be addressed through outpatient therapy, medications, and medication reviews covered under his MHP.

The testimony and clinical records contained in the record do not show any clinically significant residual disability, symptoms, or impairments relating to a mental illness. Appellant's impairment appears to be primarily due to his substance abuse issues. Accordingly, there is no showing of a need for specialized mental health services to address any such residual symptoms or impairments, or to prevent a relapse. Appellant is currently receiving substance abuse treatment. He can receive any further medication or psychiatric services, as well as, any other ongoing outpatient mental health services, through his MHP.

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 medical necessity or eligibility requirements for Medicaid Specialty Supports and Services through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/22/2011

***** 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 Administrative Tribunal 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