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) 373-4147

IN THE MATTER OF

Appellant

Docket No. 2013-21822 CMH
Case No.

_______________________/

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 Appellant's mother and guardian, appeared and testified on Appellant's behalf. ; and Goal Coordinator, appeared as witnesses for Appellant.

, Fair Hearing Officer, represented Community Mental Health (CMH or). , appeared as a witness for .

ISSUE

Did CMH properly deny authorization for personal care services for Appellant?

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 year-old Medicaid beneficiary with a diagnosis of Down's syndrome and mild mental retardation. (Exhibit G, p 3)

2. Appellant resides in a Licensed Adult Foster Care home. (Exhibit E, Testimony)

3. Petitioner had been receiving case management and personal care services. (Exhibit G, Testimony).

4. On [redacted] for CMH, conducted a review of Appellant's file. [redacted] concluded that medical necessity for continued personal care services no longer existed because Appellant was found to be very independent with ADL's and mostly needed prompting and reminding to conduct these tasks. (Exhibit B; Testimony)

5. An Action Notice and Hearing Rights form was sent to Appellant on [redacted] denying Appellant's request for personal care services. (Exhibit A)

6. On [redacted] Appellant's guardian requested a local appeal. (Exhibit C).

7. On [redacted], [redacted], upheld the local appeal, concluding that:

   > In reviewing the Licensing Rules for Adult Foster Care Large Homes (13-20) the items requested by [redacted] for specialized personal care are already an expectation that the home provide as a licensed setting. The home is already expected and paid for (through AFC payment) the below mentioned services and supports and there is no justification in the request to indicate needs cannot be met through the AFC licensed responsibilities. In addition the home is eligible for additional MPS monies (if not receiving already) for care needs in the home. (Exhibit D)

8. The Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (Exhibit 1).

9. On [redacted], [redacted] met with Appellant's guardian. It was determined during the meeting that Appellant was eligible for Community Living Supports (CLS) and Appellant bas begun receiving CLS. (Exhibit F; Testimony)

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.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/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.

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 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. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support 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, 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, 2013, pp 12-14

Personal Care Services are also defined in the Medicaid Provider Manual:

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by DHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by

prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed and certified by the state under the 1987 Department of Mental Health Administrative Rule R330.1801-09 (as amended in 1995).

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

MPM, Mental Health Substance Abuse Section; April 1, 2013, pp 62-63

The Licensing Rules for Adult Foster Care Large Group Homes (13-20) provide:

R 400.15303 Resident care; licensee responsibilities.

Rule 303.

(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.

(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.

(4) A licensee shall provide all of the following:

(a) An opportunity for the resident to develop positive social skills.

(b) An opportunity for the resident to have contact with relatives and friends.

(c) An opportunity for community-based recreational activities.
(d) An opportunity for privacy and leisure time.
(e) An opportunity for religious education and attendance at religious services of the resident's choice.
(5) A licensee shall provide both of the following when specified in the resident's written assessment plan:
(a) Direction and opportunity for the growth and development of a resident as achieved through activities that foster independent and age appropriate functioning, such as dressing, grooming, manners, shopping, cooking, money management, and the use of public transportation.
(b) An opportunity for involvement in educational, employment, and day programs.
History: 1994 MR 3, Eff. May 24, 1994.

testified that when she conducted a review of Appellant's file, she discovered that Appellant did not need hands on assistance with his personal care needs, but rather just needed reminders and prompting. (Exhibit B) For example, indicated that Appellant required prompting for oral care, laundry, and showering, but not hands on personal care. also testified that after meeting with Appellant's guardian and representatives from his AFC home, she determined that CLS would be more appropriate for Appellant, so that he could be taught to be even more independent with ADL's.

Appellant's mother/guardian testified that one of the areas where Appellant did need more than prompting or reminding was in showering. Appellant's mother/guardian indicated that staff needed to not only remind Appellant to shower, they would also need to help him control the water temperature in the shower and stand by to supervise him. Appellant's mother/guardian testified that she wanted to make sure that was being compensated for all of the extra care they provided to Appellant and also to ensure that Appellant was not taking staff away from assisting other residents. Appellant's mother/guardian also testified that Appellant recently developed a sore on his nose and that staff at have to watch him constantly to make sure he does not scratch or pick at it. Appellant's mother/guardian also indicated that Appellant has a tumor in his eye and that staff must also watch him constantly to make sure that he does not touch it. Appellant's mother/guardian testified that Appellant also needs assistance with oral care because he has to brush four times per day, per his dentist's orders. Appellant's mother/guardian testified that Appellant continues to develop additional ailments that require additional staff time to care for.

testified that as other conditions arise that require additional care services, those services will be approved. indicated, however, that based on the information she had at the time she made her decision, she believed the decision was correct.

Based on the evidence presented, CMH did properly deny Appellant personal care services. As indicated above, the documentation submitted showed that Appellant only needed verbal prompts and reminders to complete his ADL's. If Appellant needs more than verbal prompts and reminders, that fact must be documented in the request for personal care services. Furthermore, the Licensing Rules for Adult Foster Care provide that the specialized personal care requested by [redacted] is already an expectation that the home provide in a licensed setting. In lieu of the personal care services Appellant was receiving, he has now been approved for CLS, which would seem to be more medically appropriate because the CLS workers can assist Appellant in learning to be even more independent in his ADL's.

The burden is on the Appellant to prove by a preponderance of evidence that personal services are still medically necessary. As indicated above, Appellant did not meet his burden.

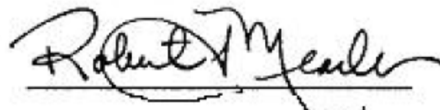
DECISION AND ORDER

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

> The CMH properly denied authorization for personal care services for Appellant.

IT IS THEREFORE ORDERED that:

> The CMH's decision is AFFIRMED.



Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: April 10, 2013

***** 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.