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:

[redacted],

Docket No. 2013-21825 CMH
Case No. [redacted]

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 hearing was held on [redacted]. Appellant appeared and testified on her own behalf.

[redacted], Due Process Manager for [redacted] Community Mental Health (CMH), represented the Department (MDCH). [redacted], MS, LLP, Utilization Coordinator for CMH's Utilization Management Department, appeared as a witness for the Department.

ISSUE

Does the Appellant meet the eligibility requirements for continued Medicaid Specialty Supports and Services including additional individual therapy sessions 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]) Medicaid beneficiary, who had been receiving Medicaid Specialty Services and Supports of individual therapy sessions through CMH. (Exhibit A, pp. 4, 9 and testimony).

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. On [redacted], a formal request was made by Appellant's therapist to the CMH's Utilization Management Department for the authorization of 12 additional therapy sessions. (Exhibit A, Hearing Summary and testimony).

5. On [redacted], a Utilization Coordinator for CMH's Utilization Management Department completed a review of the Appellant's case. It was determined that the documentation did not support medical necessity for additional therapy units. Thereafter, CMH sent the Appellant a written adequate action notice denying the request for the 12 additional therapy units as the documentation did not support medical necessity for the additional units at that time. The notice advised that Appellant's therapist could assist her with finding community supports. The notice also informed Appellant of her right to a fair hearing. (Exhibit A, Hearing Summary and pp.1-3).

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

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.

[redacted], a limited licensed psychologist with CMH, testified she was not the original reviewer of the Appellant's case on [redacted]. However she did review the case prior to the hearing. [redacted] noted the adequate action notice sent out on [redacted], indicated the request for the 12 additional therapy units was denied as the documentation did not support medical necessity for the additional units at that time. (Exhibit A, p.1).

[redacted] stated Appellant's Individual Plan of Service authorized 12 therapy sessions in [redacted], and in December a request for an additional 12 sessions was received by Utilization Management. (Exhibit A, pp. 4-9). [redacted] stated she reviewed the progress notes from Appellant's therapy sessions. (Exhibit A, pp. 10-50). [redacted] stated the records showed the Appellant had a low grade chronic depression; there was no indication of severe symptoms indicating that the Appellant had a serious mental illness.

[redacted] stated in order for additional therapy sessions to be covered by Medicaid, Appellant would have to have severe symptomatology. The Appellant would have to be seriously mentally ill. [redacted] stated she did not find the Appellant eligible for Mental Health services through CMH based upon the symptoms reported in her progress notes. [redacted] further stated the Appellant does have Medicare which would cover outpatient therapy sessions for the Appellant.

This Administrative Law Judge does not have jurisdiction to order 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 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 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 was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former	□ The beneficiary does not have a current or recent (within the last 12 months) serious

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.	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, April 1, 2012, 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 *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section dated April 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, April 1, 2013, page 5.*

Appellant testified she started therapy sessions because she was fighting in court to get her kids back. She indicated she was just starting to deal with this situation within the last few months. She indicated her therapist was helping her get past her problems and helping her to realize that it wasn't her fault. Appellant stated she has been seeing the same therapist since [redacted]. She stated it did not help her court case. Appellant acknowledged that she was enrolled in Medicare.

In this case, CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid Covered mental health services and properly determined she is not. The Appellant's medical records do not support either the severe symptoms or a serious mental illness which is required to qualify her for Medicaid eligibility as a person with a serious mental illness. (Exhibit A, pp. 10-50). Accordingly, Appellant is not currently entitled to receive Medicaid covered mental health services through CMH. Any further therapy sessions that the Appellant might require can be covered by Medicare.

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 including additional individual therapy sessions through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/12/2013

***** 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 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.