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:

Docket No. 2013-34833 CMH

[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] brother and Guardian, represented Appellant. [redacted] attorney and Due Process Hearings Coordinator, appeared on behalf of the [redacted] County Community Mental Health Services Program (CMH or Department). From [redacted] Mental Health Liaison and former Access Screener, and [redacted] Mental Health Liaison Manager, appeared as witnesses for the CMH.

ISSUE

Did the CMH properly determine that CMH services were not medically necessary for the 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 CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

2. The CMH in turn contracts with various service providers, including [redacted].

3. The Appellant is a [redacted]-year-old female that has been diagnosed with schizophrenia and several physical health issues. (Exhibit B, page 1)

4. The Appellant lives in an adult foster care facility. (Mental Health Liaison Testimony)

5. In [redacted] the Appellant initially presented at [redacted] and requested CMH services. An initial screening was completed. The Appellant was requesting case management services with access to psychiatry. A LOCUS evaluation was completed and the Appellant scored 14. (Mental Health Liaison Testimony)

6. It was determined that the Appellant did not meet the criteria for full case management services and while she would benefit from continued psychiatric treatment, the Appellant could access psychiatric services and in the community with [redacted] and [redacted]. The recommendation was for the Appellant and her brother to follow up with a Supports Coordinator for short term case management. (Mental Health Liaison Testimony)

7. On [redacted] sent the Appellant an Adequate Action Notice denying services because they were not medically necessary. (Exhibit A, pages 1-2)

8. A second LOCUS evaluation was completed and the Appellant scored 13. (Exhibit C; Mental Health Liaison Testimony)

9. On [redacted] the [redacted] sent the Appellant a letter indicating there had been a second opinion. The second opinion was also that Appellant was not eligible for services because they were not medically necessary. (Exhibit A, pages 3-4)

10. On [redacted] sent an Advance Action Notice to Appellant notifying her supports coordination "services will be terminated within thirty days of services" because they were not medically necessary. (Exhibit A, pages 5-6)

11. On [redacted] the Michigan Administrative Hearing System received the request for hearing filed on the Appellant's behalf. The hearing request stated the Appellant is seeking assignment of a psychiatrist and psychiatric services and assignment of a case manager and case management services.

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

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.

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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.

MPM, Mental Health and Substance Abuse Section, January 1, 2013, Pages 12-13

Case Management services are also defined in the Medicaid Provider Manual:

SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and

other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

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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.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.

- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.

- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. 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.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. 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.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

MPM, Mental Health and Substance Abuse Section,
January 1, 2013, Pages 74-75

The Mental Health Liaison was formerly an access screener and she completed the initial screening for the Appellant. Information was provided by the Appellant, her brother, and the group home manager. The Appellant requested case management services with access to psychiatry. The initial screening involved an interview of about 45 minutes and a LOCUS evaluation. The Appellant scored 14 on the initial LOCUS evaluation. The score range of the LOCUS is 0 to the high 20's, and the Appellant's scored 14. This score level is just above no services needed and indicating eligibility for some services from the community. There was a second opinion, and another person completed a second LOCUS evaluation. The Appellant scored 13 on the second LOCUS evaluation. It was determined that the Appellant did not meet the criteria for full case management services and while it appeared she would benefit from continued psychiatric treatment, noting that the Appellant could access psychiatric services and in the community with [redacted] and [redacted] The recommendation was for the Appellant and her brother to follow up with a Supports Coordinator. The Supports Coordinator works with persons who are not eligible for high intensity CMH services. Rather, this is short term case management for transitions, referrals and/or pressing concerns for about a month's time. (Mental Health Liaison Testimony; Exhibits A-C)

The Appellant's brother disagreed with the denial and testified there were no major issues with the screening/scoring, though he noted that in a 45 minute screening maybe some nuances with the Appellant remained hidden. The Appellant's brother stated the Appellant had received services through [redacted], specifically case management and psychiatric services. Then the Appellant moved to an adult foster care. The Appellant had psychiatric services with a provider that came to the adult foster care, which kept her stable. The psychiatric service provider was leaving the area at the time of this request for CMH services. At the time of the [redacted] hearing proceedings, the Appellant did not have psychiatric services in place, but the Appellant's brother was continuing to work with the Supports Coordinator to try to establish services with another provider. There has been no success so far in finding another provider for psychiatric services. (Brother Testimony; Mental Health Liaison Testimony)

Based on the evidence presented, CMH properly determined that CMH services were not medically necessary for the Appellant at that time. The Appellant was living in the adult foster care, psychiatric services were still in place, the Appellant was stable and it appeared that psychiatric services would be available to the Appellant in the community through her Medicaid and Medicare coverage. At that time, the short term case management was sufficient to meet the Appellant's needs. Therefore, the more intensive CMH services were not medically necessary. The burden is on the Appellant to prove by a preponderance of evidence that case management services were medically necessary. As indicated above, the Appellant did not meet her burden.

However, as discussed during the hearing proceedings, the Appellant and her brother should continue to work with the Supports Coordinator for short term case management, including trying to find psychiatric services for the Appellant in the community. Further, if there are any changes from the circumstances at the time of the [redacted] request, a new request for CMH services can be made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for CMH services as not medically necessary at the time of the request based on the available information.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

***** 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.