

**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. 2013-42275 CMH  
Case No. ██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.* and upon the request for a hearing filed by Appellant/Petitioner.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, ██████████ Customer Services Manager, appeared and testified on behalf of Respondent ██████████ (BABH). ██████████, outpatient therapist, and ██████████, outpatient clinical supervisor, also testified as witnesses for BABH.

**ISSUE**

Did BABH properly deny Appellant's request to have her outpatient therapy services reinstated?

**FINDINGS OF FACT**

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

1. BABH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH's service area.
2. Appellant is a ██████ year-old Medicaid beneficiary female who has been diagnosed with major depression, anxiety, and panic disorder. (Respondent's Exhibit 1, pages 1, 3).
3. Appellant was referred to BABH in ██████████ and has been receiving services since that time. (Respondent's Exhibit 1, page 1; Testimony of Appellant).

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4. Among the services Appellant received was monthly outpatient therapy. She began receiving such therapy in [REDACTED]. (Respondent's Exhibit 2, page 1).
5. By [REDACTED], [REDACTED] was Appellant's outpatient therapist. (Testimony of Appellant; Testimony of [REDACTED]).
6. Beginning in [REDACTED], [REDACTED] and Appellant began discussing transitioning Appellant out of outpatient therapy due to Appellant's progress and stability. The transition process was to take place over several months. (Testimony of [REDACTED]).
7. In [REDACTED], Appellant's person-centered plan was amended to indicate a termination of her outpatient therapy the next month and the addition of Peer Supports services. (Respondent's Exhibit 8).
8. She also began receiving Community Living Supports (CLS) at that time. (Testimony of [REDACTED]).
9. In [REDACTED], Appellant and [REDACTED] had a final outpatient therapy session and her outpatient therapy was terminated. (Testimony of [REDACTED]; Testimony of [REDACTED]).
10. Appellant agreed with the termination of outpatient therapy at that time. (Testimony of Appellant).
11. Since the termination of outpatient therapy, Appellant has been going to the drop-in center often and she reports that it does help. She also goes to a peer supports group once a month. (Testimony of Appellant).
12. Appellant further testified that, in general, she has remained the same since her outpatient therapy was terminated. (Testimony of Appellant).
13. However, Appellant's family advised her that she still needs therapy and Appellant also testified that she feels better when seeing [REDACTED] every two weeks. (Testimony of Appellant).
14. Appellant requested that her outpatient therapy be reinstated. (Testimony of Appellant).
15. On [REDACTED], BABH sent Appellant a negative action notice with respect to her request. (Respondent's Exhibit 3, pages 1-2).<sup>1</sup>

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<sup>1</sup> The notice sent to Appellant mistakenly stated that her services were being reduced rather than that her request for outpatient therapy was being denied. However, that error was harmless as there was no new reduction in services at that time and Appellant was able to appeal the denial.

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16. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received Appellant's Request for Hearing. (Petitioner's Exhibit 1, page 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.]

Moreover, 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

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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. BABH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Appellant requested reinstatement of outpatient therapy and, as provided in the applicable version of the Michigan Medicaid Provider Manual, therapy is a Medicaid covered service:

**3.11 INDIVIDUAL/GROUP THERAPY**

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker. [MPM, January 1, 2013 version, Mental Health/Substance Abuse Chapter, page 18.]

However, Medicaid beneficiaries are only entitled to medically necessary 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. See 42 CFR 440.230.

With respect to medical necessity, the MPM provides:

**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;
- Based on clinical information from the

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beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

[MPM, Mental Health/Substance Abuse Chapter, pages 12-13.]

Appellant bears the burden of proving by a preponderance of the evidence that BABH erred in denying her request for reinstatement of outpatient therapy. Given the evidence in this case, Appellant has failed to meet that burden of proof and the denial must be affirmed.

BABH terminated Appellant's outpatient therapy in [REDACTED] because of the improvement and stability Appellant had shown. That improvement is documented in multiple progress reports and Appellant was only slowly transitioned out of outpatient therapy. At the time of the termination, it was [REDACTED] professional opinion that the therapy was no longer necessary. Appellant also agreed with ending the therapy at that time.

Additionally, Appellant testified that she has generally been stable since the termination of outpatient therapy and that not much has changed since that time. She did testify

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that she feels better when seeing [REDACTED] every two weeks, but nothing in her testimony indicates that outpatient therapy is medically necessary.

Moreover, while Appellant still has a need for some assistance, her current needs are being met by other Medicaid covered services, such as peer-delivered services and community living supports. As described by the MPM those services generally encompass a wide variety of assistance:

**17.3.H. PEER-DELIVERED OR -OPERATED SUPPORT SERVICES**

Peer-delivered or peer-operated support services are programs and services that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

\* \* \*

**17.3.H.2. DROP-IN CENTERS**

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

\* \* \*

**17.3.B. COMMUNITY LIVING SUPPORTS**

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries,

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city pools, camps, etc.). [MPM, Mental Health/Substance Abuse Chapter, pages 120-123]

Appellant reports that those services are helping her. ██████████ also testified that, in her professional opinion, peer-support services and CLS are what Appellant needs right now rather than meeting with a therapist given the state of Appellant's mental health and Appellant's need to socialize and be integrated into other groups and the community.

Given the assistance provided by Appellant's current services; ██████████ professional opinion, and Appellant's previous improvement and stability prior to her therapy being terminated; Appellant failed to meet her burden of proving that BABH erred in denying her request for outpatient therapy.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the BABH properly denied Appellant's request to have her outpatient therapy services reinstated.

**IT IS THEREFORE ORDERED** that:

BABH's decision is **AFFIRMED**.

*Steven Kibit*

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

██████████  
Date Signed: 7/17/2013

Date Mailed: 7/17/2013

cc: ██████████

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**\*\*\* 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.