

**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. 2013-47833 CMH  
Case No. ██████████

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**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 ██████████. ██████████, Appellant's father, appeared and testified on Appellant's behalf.

Attorney ██████████, Corporate Counsel for ██████████ County Community Mental Health and Substance Abuse Services (CMH or ██████████), represented the Department. ██████████, MA, LLP, Utilization Review Coordinator, and ██████████, Customer Service Specialist, appeared as witnesses for the ██████████.

**ISSUE**

Did CMH properly terminate Appellant's psychiatric services?

**FINDINGS OF FACT**

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

1. Appellant is a ██████ year-old Medicaid beneficiary, born ██████████. Appellant is diagnosed with Pervasive Developmental Disorder NOS, Posttraumatic Stress Disorder, Impulse Control Disorder NOS, Mood Disorder NOS, Reactive Attachment Disorder of Infancy or Early Childhood, Attention-Deficit/Hyperactivity Disorder, Moderate Mental Retardation, and Cognitive Disorder NOS. (Exhibit A, p 11)
2. Appellant receives special education services at school, has been doing well, and is on the verge of transitioning back to public school. Appellant's attendance has been outstanding and he is following the rules. (Exhibit A, p 8)
3. Appellant is prescribed the medications Adderall XR, Clonidine, Trileptal and Zoloft. (Exhibit A, p 11)

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4. Appellant lives in the family home. Prior to age 10 he lived with biological relatives and then in a series of foster homes. He and one of his biological brothers were adopted into Mr. Talton's family. (Exhibit A, p 7)
5. Appellant has been receiving psychiatric services through CMH since [REDACTED]. (Exhibit A, p 7; Testimony).
6. On [REDACTED], CMH conducted a utilization review of Appellant's services following a local appeal of the decision to terminate Appellant's psychiatric services. (Exhibit A, pp 6-12). CMH concluded that medical necessity for continued psychiatric services no longer existed because Appellant's CAFAS score had decreased to 40, the only service he had needed or received had been quarterly medication monitoring, he had had no recent medication changes, he had met all the goals in his plan of service, and he was doing well at school. CMH concluded that the routine quarterly psychiatric services Appellant was receiving were available to him through his Medicaid HMO. (Exhibit A, p 12; Testimony)
7. On [REDACTED], CMH sent an Advance Action Notice to the Appellant indicating that his psychiatric services would be terminated effective June 6, 2013. The Notice included rights to a Medicaid fair hearing. (Exhibit A, pp 3-4).
8. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [REDACTED]. (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...

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.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, April 1, 2013, Pages 12-14*

The CMH witness testified that on ██████████, she conducted a utilization review of Appellant's services following a local appeal of the decision to terminate Appellant's psychiatric services. (Exhibit A, pp 6-12). The CMH witness concluded that medical necessity for continued psychiatric services no longer existed because Appellant did not demonstrate a need for specialized CMH services. Specifically, the CMH witness indicated that Appellant's CAFAS score (a tool used to measure how a child is doing in the different domains of life) had decreased to 40, a level that was quite low and evident of someone doing quite well. The CMH witness also indicated that the only service

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Appellant had needed or received in the past year had been quarterly medication monitoring, that he had had no recent medication changes, he was doing well at school, and he had met all of the goals in his plan of service. The CMH witness pointed out that the routine quarterly psychiatric services Appellant was receiving (medication reviews) are available to him through his Medicaid HMO. The CMH witness indicated that Appellant would be entitled to 20 psychiatric visits per year through his HMO and that he had only been using 4 visits per year through CMH. The CMH witness testified that Appellant receiving medication reviews through his HMO would be a less-restrictive, more cost-effective way for him to receive services.

Appellant's father testified that Appellant still needs his psychiatric services. Appellant's father indicated that he needed a specialized license to adopt Appellant because of Appellant's special needs. Appellant's father indicated that Appellant has been hospitalized in a psychiatric hospital in the past, before he adopted Appellant approximately █ years ago. Appellant's father testified that when he and Appellant are meeting with the psychiatrist, he does not always elaborate on all of the problems Appellant has been having because he does not want to do so in front of Appellant and make him feel bad. Appellant's father spoke about an incident that occurred in █ when the police were called to Appellant's school when Appellant bit a teacher. (Exhibit 2). Appellant's father testified that Appellant has always received services from the state those services should continue. Appellant's father entered into the record letters from Appellant's doctor and his past foster parents, all of whom indicated that Appellant still needed services. The letters were from █ and █. (Exhibit 5). Appellant's father also entered information he received from Appellant's school, but that information supports the CMH's conclusion that Appellant is doing well in school. (Exhibit 4). Appellant's father testified that Appellant does not get along with the other children in his home and that the police were called to his home this past winter because Appellant would not come in out of the cold.

On cross examination, Appellant's father indicated that he understood that Appellant could receive services elsewhere, but testified that he wanted Appellant to continue to receive services through CMH.

Based on the evidence presented, CMH did properly terminate Appellant's psychiatric services. As indicated above, all services must be medically necessary, meaning those services are, "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." Furthermore, the MPM provides that a CMH may deny services "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." Here, Appellant's CAFAS score has decreased to 40, the only service he has needed or received in the past year has been quarterly medication monitoring, he has had no recent medication changes, he has met

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all of the goals in his plan of service, and he is doing well at school. Furthermore, the routine quarterly psychiatric services Appellant was receiving are available to him through his Medicaid HMO. As such, Appellant no longer meets the medical necessity criteria to receive psychiatric services through CMH because those services are available in a less restrictive, more cost effective setting and because Appellant has met the goals he set through CMH. Appellant's father repeated several times during the hearing that Appellant's services should not be stopped. As indicated above, the services Appellant is receiving will continue; they will just need to be arranged through Appellant's Medicaid HMO.

The burden is on Appellant to prove by a preponderance of evidence that psychiatric services through CMH are still medically necessary. As indicated above, Appellant did not meet this burden.

**DECISION AND ORDER**

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

The CMH properly terminated Appellant's psychiatric services.

**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:

Date Signed: July 24, 2013

Date Mailed: July 24, 2013

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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.