

**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. 2013-55084 CMH

██████████

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 ██████████ ██████████ ██████████, Appellant's mother, appeared and testified for the Appellant. Appellant also testified on his own behalf.

Attorney ██████████, Corporation Counsel for ██████████ County Community Mental Health and Substance Abuse Services, hereinafter CMH, represented the CMH. Ms. ██████████, MA, LPC, LBSW, CAADC, Quality Improvement Manager with the ██████████, the PIHP serving ██████████ County, appeared and testified on behalf of CMH.

ISSUE

Was the CMH's termination of the Appellant's Medicaid covered case management and psychiatric services in accordance with policy?

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 (██████████) who has been receiving case management and psychiatric services authorized through CMH. (Exhibit A, pp. 1, 3, 6, 9 and testimony).
2. ██████████ Community Mental Health & Substance Abuse Services (CMH) is responsible for providing Medicaid-covered mental health and developmental disability services to eligible recipients in its service area.

3. On or about [REDACTED] CMH sent the Appellant an advance action notice that his Medicaid covered case management and psychiatric services would be terminated effective [REDACTED]. The reason given was Appellant did not meet the medical necessity criteria for CMH to continue authorization of these services. (Exhibit A, pp. 1-3, and testimony).
4. On [REDACTED] Appellant filed a local appeal regarding the termination of the Medicaid covered services authorized by CMH. (Exhibit A, p. 3).
5. On [REDACTED], [REDACTED], MA, LPC, RN, a Utilization Review Coordinator with the [REDACTED] Affiliation, the PIHP serving [REDACTED] County conducted a Utilization Management Review. Ms. [REDACTED] supported the termination of Appellant's case management and psychiatric services. (Exhibit A, pp. 3, 9-16).
6. On [REDACTED], CMH sent Appellant a letter notifying him that his local appeal resulted in a determination to uphold the decision to terminate his case management and psychiatric services authorized through CMH. The letter informed Appellant of his rights to a Medicaid fair hearing. (Exhibit A, pp. 3-4 and testimony).
7. The Appellant's request for hearing was received by MAHS on [REDACTED] (Exhibit A, p. 5).

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 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 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.

The evidence presented in this case demonstrates that on or about [REDACTED] Appellant was sent an Advance Action Notice that his case management and psychiatric services were to be terminated effective [REDACTED]. The Appellant appealed the denial on [REDACTED].

The CMH must follow the Department's Medicaid Provider Manual when approving or denying mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria, April 1, 2013, Section 2.5* lists the criteria the CMH must apply as follows:

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 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.

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;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- 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. [pp. 12-14].

CMH has presented substantial credible evidence in this case that they properly determined the Appellant's case management and psychiatric services should be terminated because the Appellant did not meet the medical necessity criteria for continued authorization of these services. A Utilization Management Review of the

Appellant's case in connection with his local appeal by Ms. ██████ along with the rest of the Utilization Management Team demonstrated that the Appellant has made significant progress in meeting the goals and objectives contained in his person centered plan. It was further determined that continued authorization by CMH of Appellant's case management and psychiatric services was not clinically necessary to meet the Appellant's current needs and that other services available to the Appellant in a less restrictive setting would be sufficient to meet these needs.

The Utilization Management Review showed the Appellant has remained stable during the past year, and he had been able to maintain and coordinate services through his Medicaid HMO. Appellant is living independently with assistance from his mother. Appellant is familiar with and able to manage his medications. Appellant has required less frequent contact with his Case Manager ██████████. Appellant has greatly improved control over his behavior and demonstrates improved social functioning. Appellant has made progress in ambulating with use of his walker. The review also found no aggressive behavior documented within the past ██████ years.

The Utilization Management Review also showed there has been no need to change the Appellant's medications in the past several years, and that his personal care physician or a psychiatrist authorized by his Medicaid HMO would be able to assist the Appellant with managing his medications and provide any additional counseling or psychiatric services needed by the Appellant. Finally, the review identified community based supports and services such as ██████████ and ██████████ that would also be available to the Appellant to meet his on-going needs.

The Appellant and his mother provided testimony that shows the Appellant still has a need for services, and he has become comfortable with his current case manager and would like to keep him around to provide additional support when the Appellant's mother is not available. It was expressed that the Appellant feels like the rug has been pulled out from underneath him and he doesn't want to be just thrown to the wolves. In response, the CMH reassured the Appellant and his mother that they would be providing a transition from the CMH authorized services to those otherwise available to the Appellant through his Medicaid HMO and other community based resources.

A review of the evidence presented in this case shows that continued authorization by CMH of Appellant's case management and psychiatric services is not clinically necessary to meet the Appellant's current needs and that other services available to the Appellant through his Medicaid HMO and available community based services would be sufficient to meet the Appellant's needs. In short, the evidence shows the CMH acted properly by terminating the Appellant's case management and psychiatric services.

The Appellant bears the burden of proving that the CMH did not act properly when it terminated his case management and psychiatric services. The CMH provided sufficient evidence that continued authorization by CMH of Appellant's case management and psychiatric services is not clinically necessary to meet the Appellant's current needs and


that there were other services available to the Appellant in a less restrictive setting that could meet the Appellant's current needs. It is proper for the CMH to terminate 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. The CMH provided sufficient evidence that medical necessity no longer exists for Medicaid covered case management and psychiatric services in this case. Accordingly, the CMH acted appropriately in terminating the Appellant's case management and psychiatric services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH's termination of Appellant's Medicaid covered case management and psychiatric services was in accordance with policy.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/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.