

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. 2013-57258 CMH
Case No. ██████████

_____ /

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 appeared on her own behalf.

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

Following the hearing, the record was held open until ██████████ so that Appellant could provide a written response to the information contained in the Department's Hearing Summary, which Appellant did not receive until the date of the hearing. Appellant was advised to bring her written statement to CMH by ██████████ and that they would fax the information to the Michigan Administrative Hearing System. As of the close of business on ██████████, no such written response was received from Appellant.

ISSUE

Did CMH properly terminate Appellant's psychiatric medication reviews and case management 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 schizoaffective disorder, as well as cocaine and marijuana dependence. (Exhibit A, p 8; Testimony)

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2. Appellant is prescribed the medications Abilify, Depakote ER, and Zyprexa. (Exhibit A, p 9)
3. Appellant lives with her ██████ year old son and, at times, they live with Appellant's ██████ year old mother when housing support is needed. (Exhibit A, p 7; testimony)
4. Appellant has been receiving services through CMH and its affiliates since ██████. Currently Appellant is receiving psychiatric medication reviews, case management services, and payee/conservator services through CMH. (Exhibit A, pp 9-10; Testimony).
5. Following a review, CMH determined that Appellant's psychiatric medication reviews and case management services should be terminated and on ██████████ Appellant requested a local review of the determination. (Exhibit A, p 4; Testimony)
6. Following the local review, CMH upheld the termination of psychiatric medication reviews and case management services. (Exhibit A, pp 4-5)
7. On ██████████, CMH conducted a utilization review of Appellant's services. (Exhibit A, pp 6-12). CMH concluded that medical necessity for continued psychiatric medication reviews and case management services no longer existed because Appellant had met all of the goals in her plan, meets her own linking and coordinating needs in the community and has been stable (no hospitalizations) in the past year. The CMH determined that Appellant's medications could be prescribed by her family physician. CMH also determined that Appellant's substance use issues are a concern and that substance abuse treatment services would be offered as an additional service. (Exhibit A, pp 10-12; Testimony)
8. On ██████████, CMH sent an Advance Action Notice to the Appellant indicating that her psychiatric medication reviews and case management services would be terminated. The Notice included rights to a Medicaid fair hearing. (Exhibit A, pp 4-5).
9. Appellant's request for hearing was received by the Michigan Administrative Hearing System on ██████████. (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. Lifeways 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.

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 medication reviews and case management services. (Exhibit A, pp 6-12). CMH concluded that medical necessity for continued psychiatric medication reviews and case management services no longer existed because Appellant had met all of the goals in her plan, meets her own linking and coordinating needs in the community and has been stable (no hospitalizations) in the past year. The CMH determined that Appellant's medications could be prescribed by her family physician. CMH also determined that Appellant's substance use issues are a concern and that substance abuse treatment services would be offered as an additional service.

Appellant testified that she needed additional time to review the hearing summary, which was provided to her on the date of the hearing because Appellant had provided the wrong address on her request for hearing. Appellant was given until ██████████ to provide a written response. CMH indicated that they would assist Appellant with faxing the response to MAHS. As indicated above, as of the close of business on ██████████, no such written response was received from Appellant.

Based on the evidence presented, CMH properly terminated Appellant's psychiatric medication reviews and case management 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." Here, CMH properly concluded that medical necessity for continued psychiatric medication reviews and case management services no longer existed because Appellant had met all of the goals in her plan, meets her own linking and coordinating needs in the community and has been stable (no hospitalizations) in the past year. The CMH determined that Appellant's medications could be prescribed by her family physician, which would be a more cost effective method for her to receive her prescriptions. CMH also determined that Appellant's substance use issues are a concern and that substance abuse treatment services would be offered as an additional service. (Exhibit A, pp 10-12; Testimony). Given the above, Appellant no longer meets the medical necessity criteria to receive psychiatric medication reviews and case management services through CMH.

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

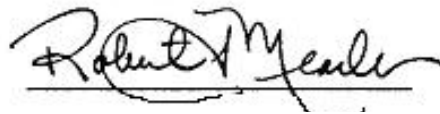
DECISION AND ORDER

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

The CMH properly terminated Appellant's psychiatric medication reviews and case management 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

[REDACTED]
cc: [REDACTED]

Date Signed: 9/18/2013

Date Mailed: 9/18/2013

***** 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.