

**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. 2013-58216 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 ██████████
parents, represented the Appellant.

██████████, Corporate Counsel, represented the ██████████ ██████████
██████████ (CMH or Department). ██████████ Utilization
Review Coordinator, and ██████████, Customer Services Manager, appeared as
witnesses for the Department.

ISSUE

Did the CMH properly deny the Appellant's request for Community Living Supports (CLS) services and terminate the 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. The Appellant is a ██████-year-old Medicaid beneficiary who has been receiving Psychiatric services through the CMH. (Exhibit 1, pages 1 and 8)
2. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.
3. The Appellant has been diagnosed with Asperger's Syndrome, ADHD, OCD, Circadian Rhythm Sleep Disorder, Asthma, Intermittent Explosive Disorder, Pervasive Developmental Disorder, Mood Disorder, and rule out Mood Disorder due to medical conditions. (Exhibit 1, page 13; Exhibit B)

██████████
Docket No. 2013-58216 CMH
Decision and Order

4. The Appellant lives with his parents and ██████-year-old brother. The Appellant attends school and was on the football team. (Exhibit 1, pages 8-14)
5. The CMH determined that the Appellant's request for CLS services should be denied and the Psychiatric services should be terminated because the Appellant did not meet medical necessity criteria. (Exhibit 1, pages 1-2, 5-6, and 8-14)
6. On ██████████, the Appellant's Child and Adolescent Functional Assessment Scale (CAFAS) score was ██████. (Exhibit 1, page 8)
7. On ██████████, the Appellant's ██████ score was ██████. (Exhibit 1, page 8)
8. The clinician advised the Appellant's parents that all services would be ending due to lack of medical necessity. (Exhibit 1, page 8)
9. On ██████████, the Michigan Administrative Hearing System received Appellant's request for hearing. (Exhibit 1, page 3)
10. On ██████████, a Utilization Management Review was completed. The Utilization Coordinator recommended that the termination of the Appellant's services be upheld. (Exhibit 1, pages 8-14)
11. On ██████████, the CMH sent an Appeal Disposition to Appellant stating the determination to deny the request for CLS and terminate the Psychiatric services was upheld because medical necessity for the services was not met. The notice indicated that the Appellant may indeed continue to benefit from the services of a psychiatrist, which he has access to through his Medicaid Health Plan. Regarding the CLS, the notice indicated that the Appellant has community based activities to participate in to help him increase social skills. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pages 5-6)

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.

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;

██████████
Docket No. 2013-58216 CMH
Decision and Order

- 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.

*Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
July 1, 2013, Pages 12-14
(Underline added by ALJ)*

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve his goals.

On ██████████, a Utilization Management Review was completed. The Utilization Review Coordinator has a masters of arts in counseling psychology, is a licensed professional counselor, a limited licensed psychologist and registered nurse. The review noted that during the opening of home-based services, Families and Community Treatment (FACT), the Appellant's parents declined the suggestion for Link (CLS services) and outpatient therapy. In ██████████ the Appellant's mother called the primary worker to cancel all scheduled home based therapy contacts and rescinded authorization for contact between the clinician and the Appellant's school. On ██████████, the Appellant's CAFAS score was ██████. On ██████████ the Appellant's CAFAS score was ██████. The records showed that the Appellant had been on the school football team for two years, his GPA was over ██████ but also that he is bullied at school. The Appellant's psychiatric status was evaluated at Level 1: stable, no medication changes and appointments once per quarter. According to customer services, the Appellant's mother had discontinued all medications. The service outcome for the last six months notes that: the Individual Plan of Service (IPOS) had one goal with four objectives; the Appellant's basic success improved and the family worked together to attempt to resolve/treat his sleep disorder; and at home there were reports of significantly increased harmony. The Utilization Review Coordinator recommended the

Docket No. 2013-58216 CMH
Decision and Order

termination of the Appellant's services be upheld. (Exhibit 1, pages 8-14; Utilization Review Coordinator Testimony) The rationale noted:

[The Appellant's] behaviors and symptoms have stabilized, with a most recent CAFAS of 70, indicating no need for home based services. His medications had not been changed in the past 2 med reviews and had in fact been changed back to what was prescribed prior to the most recent neurology consult at the University of Michigan. Psychiatry is available through his Medicaid HMO and is provided as a specialty service at the agency where he receives primary care (WMED), which presents as an ideal integrated health care plan. CLS for social skills development does not present as medically necessary for a teen who is about to begin his 3rd year on the high school football team and who was scheduled to work in corn detasseling over the summer. CLS services are intended for individuals who do not have the social skills to manage these types of community activities.

(Exhibit 1, page 14)

Accordingly, the CMH sent an Appeal Disposition to Appellant stating the determination to deny the request for CLS services and uphold the termination of Psychiatric services because medical necessity for the services was not met. The notice indicated that the Appellant may indeed continue to benefit from the services of a psychiatrist, which he has access to through his Medicaid Health Plan. Locally, the Appellant can work with [REDACTED] to continue care. CMH Psychiatric services are considered a 'specialty' level of care and typically treat individuals who are unable to benefit from doctors in the community. The transfer out of a CMH clinic is a statement of how well the Appellant has been doing with medication management. Regarding the CLS, the notice indicated that the Appellant has community based activities to participate in to help him increase social skills. A CMH does not typically authorize this service when other activities opportunities are available to meet the same need. (Exhibit 1, pages 5-6)

The Appellant's parents disagree with the termination. The Appellant's father did not dispute what the Utilization Review Coordinator put down, but asserted that she did not get all of the information and received incorrect information. It was asserted that the Appellant has not been stable; rather there have been behavioral issues at school and at home. The Appellant did not do well socially at football camp and has since pulled out of football. Even when the Appellant was in football, the Appellant's mother was still there for every practice and every game. The Appellant's parents paid [REDACTED] to the school for the Appellant to participate in football. The Appellant never went to work detasseling corn over the summer because he was not mature enough. The Appellant's father had to call the police on the Appellant in [REDACTED]. The Appellant's father did not call crisis intervention because he thought the Appellant would respond better to police presence. (Parent's Testimony)

██████████
Docket No. 2013-58216 CMH
Decision and Order

The Appellant's parents testified that they never declined the CLS services. Rather, they have been trying to get the Appellant into the Link program for years and were told the Appellant has been on a waiting list. The Appellant's parents have recently learned there is no waiting list for the Link program CLS services. Further, the Appellant's parents stated the Appellant's mother never called to terminate ██████████, but just wanted to change to another social worker. The Appellant's father went to the primary care physician requesting psychology for the Appellant but this was denied, because the needed service is so intense and so much work. It was noted that the Appellant's Medicaid coverage only allows for ██████ visits for the whole year. Next year they will not have the money to pay out of pocket for services for the Appellant. (Parent's Testimony)

The Appellant's parents also submitted documentation from the Appellant's school from incidents dated between ██████████ and ██████████ as well as the ██████████ Individualized Education Program (IEP) Team Report. (Exhibits A and C) Letters from the psychiatric and pediatric residents treating the Appellant were also provided stating the Appellant would benefit from services that would help build positive social skills, particularly the ██████ program. (Exhibit B)

The CMH noted they were concerned with the issues raised by the Appellant's parent's testimony, including past issues with the social worker and more recent changes with the Appellant's circumstances. Particularly in light of the more recent changes, the CMH indicated it may make sense to complete a new review. However, the scope of this hearing is limited to reviewing the CMH's determination based on the information available at that time.

The Appellant bears the burden of proving by a preponderance of the evidence that the CMH determination to deny CLS and terminate Psychiatric services was incorrect. Here, the Appellant did not prove by a preponderance of the evidence that the medical necessity criteria were met to allow for ongoing services. Based on the information available for the Utilization Management Review, the denial of CLS and termination of Psychiatric services was appropriate. The documentation indicated the Appellant was doing fairly well in school, continuing to participate in football, had planned summer employment, was stable, the sleep disorder was being treated and some improvements were noted with this, and the Appellant has access to Psychiatric services through the Medicaid Health Plan. Accordingly, the CMH's determination to deny the Appellant's request for CLS services and terminate the Appellant's Psychiatric services must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant's request for CLS services and terminated the Appellant's Psychiatric services 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: 

Date Mailed: 

CL/db

cc:



***** 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.