

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

██████████,

Appellant

_____ /

Docket No. 2013-61731 CMH

██████████

██████████

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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████ the Appellant, appeared on her own behalf. ██████████, Manager of Due Process, appeared on behalf of ██████████, formerly known as ██████████ County Community Mental Health, (CMH or Department). ██████████ Psychologist with Utilization Management, appeared as a witness for the Department.

ISSUES

Did the CMH properly deny the Appellant's request for Targeted Case Management?

Did the CMH properly determine the Appellant no longer meets the eligibility requirements for Medicaid Specialty Supports and Services through the CMH resulting in the termination of Outpatient Therapy and Medication Review 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 female, born ██████████ (Exhibit 1, page 11)
2. The Appellant has Medicare and Medicaid coverage. (Exhibit 1, page 4)
3. The CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.

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4. The CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.
5. The Appellant's Axis I and II diagnoses are: schizoaffective disorder; major depressive disorder, recurrent, severe, with psychotic features; schizoid personality disorder; and borderline intellectual functioning. (Exhibit 1, pages 41 and 50)
6. The Appellant was receiving Outpatient Therapy and Medication Review services. (Exhibit 1, page 8)
7. On [REDACTED], the CMH Utilization Management Department received a formal request for authorization of Targeted Case Management for the Appellant. (Hearing Summary)
8. On [REDACTED], an Eligibility review was completed. It was noted that the Appellant has been able to maintain her activities of everyday life with no more than some mild to moderate symptoms that were able to be treated in the present level of care. Based on the screening, it was determined that the Appellant was not eligible for Medicaid Specialty Supports and Services through the CMH because she did not meet the eligibility criteria as someone with a serious mental illness or developmental disability (Exhibit 1, pages 4-7)
9. On [REDACTED], the CMH sent the Appellant a Notice and Hearing Rights for the denial of Targeted Case Management Services stating the Appellant did not meet medical necessity for case management service. The notice informed the Appellant of her right to a Medicaid fair hearing (Exhibit 1, pages 1-3)
10. On [REDACTED], the CMH sent the Appellant a Notice and Hearing Rights that the services of Outpatient Therapy and Medication Review services would be terminated effective [REDACTED] because she did not meet eligibility criteria for the services requested. It was noted that the Appellant can access outpatient services per her Medicare provider. The notice informed the Appellant of her right to a Medicaid fair hearing. (Exhibit 1, pages 8-10)
11. On [REDACTED], another Eligibility Review was completed. It was noted that the Appellant's issues appear mainly to be related to poor choices in relationships as well as to financial hardships, but not to severe psychiatric. The focus has been on issues unrelated to mental illness and she appears to have cognitive abilities to try to deal with them. Based on the screening, it was determined that the Appellant was not eligible for Medicaid Specialty Supports and Services through the CMH because she did not meet the eligibility criteria as someone with a serious mental illness or developmental disability. (Exhibit 1, pages 33-36)

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12. On [REDACTED], the Michigan Administrative Hearing System received the Appellant's request for an administrative hearing. (Exhibit 2)

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—

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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 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 *Medicaid Provider Manual, Mental Health/Substance Abuse*, section articulates Medicaid policy for Michigan. With respect to medical necessity, the Medicaid Provider Manual states:

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

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;
 - that are 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.*

With respect to Targeted Case Management, the Medicaid Provider Manual states:

SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

*Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
July 1, 2013, Page 74*

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The Michigan Mental Health Code definition of developmental disability and serious mental illness were utilized by the CMH to determine Appellant was not eligible for CMH services. Those definitions provides, in pertinent part:

(21) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

- i. Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
- ii. Is manifested before the individual is 22 years old.
- iii. Is likely to continue indefinitely.
- iv. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - A. Self-care.
 - B. Receptive and expressive language.
 - C. Learning.
 - D. Mobility.
 - E. Self-direction.
 - F. Capacity for independent living.
 - G. Economic self-sufficiency.
- v. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

MCL 330.1100a

"Serious mental illness" means:

330.1100d Definitions; S to W.
Sec. 100d.

* * * *

"Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in

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functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:

- A. A substance abuse disorder.
- B. A developmental disorder.
- C. A "V" code in the diagnostic and statistical manual of mental disorders.

MCL 330.1100d

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 medically necessary Medicaid services that are needed to reasonably achieve her goals.

The CMH witness testified that she is a Limited Licensed Psychologist. The CMH witness testified that she reviewed the Appellant's case, which included progress notes, eligibility reviews, medication reviews, psychiatric evaluation and psychosocial assessment and review. It was determined that the Appellant did not meet the eligibility criteria for services. The CMH witness testified that she did not find that level of impairment. It was also noted that the Appellant can access the same services with her Medicare insurance coverage, specifically Medication Review and Outpatient Therapy. Accordingly, the CMH denied the request for Targeted Case Management services and terminated the Medication Review and Outpatient Therapy services for the Appellant because she did not meet the eligibility criteria as someone with a serious mental illness or developmental disability. (Exhibit 1, pages 1-70; Psychologist Testimony)

The Appellant disagrees with the CMH determinations and testified she did not really understand what was being discussed during the hearing proceedings. Attempts were made to further explain the CMH actions as well as the Appellant's options to continue receiving services through her Medicare coverage instead of through the CMH. The Appellant did not know what case management was and stated she still needs the help through the CMH. The Appellant lives in her own house, receives some help at home, collects [REDACTED], and is not looking for employment. The Appellant does not have the money to pay for services out of pocket. (Appellant Testimony)

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The Appellant bears the burden of proving by a preponderance of the evidence that she is eligible for CMH services. Here, the Appellant did not prove by a preponderance of the evidence that she was eligible for CMH services because the evidence does not demonstrate that she has a level of impairment sufficient to meet the criteria for a serious mental illness or developmental disability. The symptoms at the time of the eligibility reviews were documented to be mild to moderate and were able to be treated in the present level of care. Accordingly, Targeted Case Management services were not medically necessary. Further, the services the Appellant was receiving, Medication Review and Outpatient Therapy, are available to the Appellant through her Medicare insurance. Accordingly, the CMH properly denied the request for Targeted Case Management services and terminated the Medication Review and Outpatient Therapy services.

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 Targeted Case Management and determined that the Appellant does not meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH resulting in the termination of Outpatient Therapy and Medication Review services.

IT IS THEREFORE ORDERED that:

The CMH decisions are **AFFIRMED**.

/s/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: _____

Date Mailed: _____

CL/db

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.