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:

Docket No. 14-014811 CMH

[redacted] [redacted] [redacted]

Appellant

_____/

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 [redacted], Appellant's sister, appeared and testified on Appellant's behalf. Appellant was also present. [redacted] Assistant Corporation Counsel, represented Respondent [redacted] County Community Mental Health (CMH). [redacted], Director of the CMH's [redacted], testified as a witness for Respondent.

ISSUE

Did the CMH properly deny Appellant's request for reauthorization of 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 CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to beneficiaries who reside in its service area.

2. Appellant is a [redacted] year-old male who has been diagnosed with anxiety disorder NOS and stuttering. (Respondent's Exhibit A, pages 9, 25).

3. Appellant is enrolled in [redacted] a Medicaid Health Plan (MHP). (Testimony of Appellant's representative; Testimony of [redacted]

4. Appellant had also been approved for services through the CMH, including targeted case management, medication reviews, and assessment. (Respondent's Exhibit A, pages 15, 28).

5. However, Appellant has not seen a therapist since [redacted]. (Respondent's Exhibit A, page 28; Testimony of [redacted]).

6. On [redacted], an annual assessment was performed with respect to Appellant's services. (Respondent's Exhibit A, pages 9-26).

7. During that assessment, it was noted that Appellant appears anxious and depressed, but that he was alert, cooperative and oriented to time, place, and situation. (Respondent's Exhibit A, page 15).

8. Appellant also denied and suicidal or homicidal ideations. (Respondent's Exhibit A, page 15).

9. Appellant further reported that he is stable, but needs medication to remain stable and is interested in continuing his medication management and review services. (Respondent's Exhibit A, page 15).

10. Appellant's services were then approved for another [redacted] months, with another periodic review of Appellant's services due on [redacted]. (Respondent's Exhibit A, page 28).

11. The periodic review was not completed, but a request for reauthorization of Appellant's services was made on or about [redacted]. (Respondent's Exhibit A, pages 5, 28).

12. On [redacted], the CMH sent Appellant written notice that his request for medication reviews, assessments and targeted case management was denied on the basis that the documentation submitted did not justify the requested services. (Respondent's Exhibit A, page 5).

13. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing in this matter. (Respondent's Exhibit A, page 7).

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*

Additionally,

> 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 also 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…
>
> *42 USC 1396n(b)*

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.

Here, the CMH contracts with the MDCH to provide services pursuant to its contract obligations with the Department and eligibility for those services is set by Department policy.

With respect to eligibility, the applicable version of the Medicaid Provider Manual (MPM) states:

> **1.6 BENEFICIARY ELIGIBILITY**
>
> *A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits.* (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.
>
> *MPM, July 1, 2014 version*
> *Mental Health/Substance Abuse Chapter, page 3*
> *(Emphasis added by ALJ)*

The state of Michigan's Mental Health Code defines mental illness and serious emotional disturbance as follows:

> 2. "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during 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 functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included

only if they occur in conjunction with another diagnosable serious emotional disturbance:

a. A substance abuse disorder.
b. A developmental disorder.
c. "V" codes in the diagnostic and statistical manual of mental disorders.

3. "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 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

Additionally, with respect to developmental disabilities, the Mental Health Code also provides:

(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.

b. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

MCL 330.1100a(25)

Moreover, the MPM also makes a distinction between the responsibilities of Prepaid Inpatient Health Plan (PIHPs)/ Community Mental Health Services Programs (CMHSPs) such as the CMH and Medicaid Health Plans (MHPs) such as [redacted], which Appellant is enrolled in:

> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic

and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. ▪ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental

	health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, page 3

Pursuant to the above policy, the CMH denied Appellant's request for services in this case on the basis that he is not a Medicaid beneficiary with a serious mental illness, serious emotional disturbance or developmental disability whose needs exceed the benefits of the MHP he is enrolled in. Specifically, the CMH's witness testified that all of Appellant's moderate mental health needs can be met by his MHP.

Appellant and his representative challenge that decision on appeal and, in doing so, bear the burden of proving by a preponderance of the evidence that the CMH erred in making the eligibility determination.

In this case, Appellant and his representative have failed to meet their burden of proof and the decision to deny Appellant's request for services must therefore be affirmed. Appellant reports being stable and has not seen a therapist for years. Additionally, while it is undisputed that Appellant requires medications and benefits from medication reviews, those limited mental health needs can be meet through his MHP.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/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.