

**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. 2014-10088 CMH  
Case No. ██████████

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 appeared on her own behalf. Her witness was her case manager, ██████████.

██████████, Fair Hearing Officer, ██████████ Community Mental Health (CMH), represented the Department. ██████████, Utilization Manager, appeared as a witness for the Department.

**ISSUE**

Did CMH properly deny authorization for continued case management services (CMS) for Appellant?

**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 with a diagnosis of 295.30 Schizophrenia, paranoid type. (Exhibit A, p 1; Testimony)
2. Appellant is her own guardian and resides alone in her own home. (Exhibit A, pp 1-4, ; Testimony)
3. Appellant has been receiving case management services (CMS) since ██████. (Exhibit A, p 1, Testimony)
4. On ██████████, continued CMS were requested by Appellant's case manager. (Exhibit A, pp 1, 20-23)

5. On ██████████, the CMH's Utilization Manager denied 73 out of 98 units and 9 out of 12 months of the CMS requested, finding that the services were no longer medically necessary as Appellant appeared to have few case management needs because she has secured housing, benefits, and was engaged in therapy. CMH did approve 3 additional months of case management to assist Appellant in transitioning to peer supports or community supports. (Exhibit A, pp 1-4; Testimony)
6. On ██████████, CMH sent an Action Notice to Appellant indicating that her request for 98 units and 12 months of continued case management services were denied, but that 3 additional months and 25 units of case management had been approved. The Notice included rights to a Medicaid fair hearing. (Exhibit A, pp 5-6)
7. 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*

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

*MPM, Mental Health and Substance Abuse  
Section, October 1, 2013, pp 12-13*

Case Management services are also defined in the Medicaid Provider Manual:

### **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.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

### **13.1 PROVIDER QUALIFICATIONS**

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

### **13.2 DETERMINATION OF NEED**

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports.

Justification as to whether case management is needed or not must be documented in the beneficiary's record.

### **13.3 CORE REQUIREMENTS**

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.

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- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

<b>Assessment</b>	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
<b>Documentation</b>	<p>The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs.</p> <p>The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.</p>
<b>Monitoring</b>	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

*MPM, Mental Health and Substance Abuse Section,  
October 1, 2013, pp 74-75*

CMH's witnesses testified that Appellant's request for continued CMS was denied because the services were no longer medically necessary as Appellant appeared to have few case management needs because she has secured housing, benefits, and was engaged in therapy. The CMH witnesses indicated that Appellant has shown marked improvement in the last 12 months and has been more proactive in

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independently advocating on her own behalf. The CMH witnesses also indicated that Appellant has pretty much met all of the goals in her person centered plan. (See Exhibit A, pp 20-23)

Appellant testified that her illness is chronic and will last the rest of her life. Appellant reviewed some issues she had back in ██████ and ██████ which led to police involvement and hospitalization. Appellant indicated that she does have independent housing but only because her case manager assists her each year with her property tax exemption and repairs on the home. Appellant also indicated that she does have benefits, but that her case manager assists her in maintaining those benefits when issues arise. Appellant indicated that she is in therapy, but would choose CMS over therapy if given a choice. Appellant indicated that both her therapist and her doctor believe she should remain in case management. (See Exhibits 2 and 3). Appellant also testified that she does not believe that peer or community supports would work well for her. Appellant indicated that she has difficulty making friends and trusting people and that she has developed a level of trust with her current case manager that she wishes to continue.

Appellant's case manager testified that Appellant has been successful, but only because of the assistance she receives through CMS. Appellant's case manager indicated that she is fearful that if Appellant's CMS are denied, she will regress and have struggles similar to the ones she mentioned from back in ██████ and ██████. Appellant's case manager noted that when Appellant struggles, she becomes very paranoid, combative, and resistant to taking her medications. Appellant's case manager indicated that Appellant has been court ordered to take her medications in the past and has been hospitalized in the past because of her mental health issues.

In response, the CMH Utilization Manager indicated that the legal issues and severe symptoms Appellant mentioned were from ██████ years ago and were not current. The CMH Utilization Manager indicated that CMH still supports Appellant receiving therapy through Recovery Technologies and that her therapist can assist with monitoring Appellant's medications and linking her with community services. The CMH Utilization Manager also indicated that the CMH peer support services they are trying to link Appellant with are very good.

Based on the evidence presented, CMH did properly deny Appellant's request for continued case management services. As indicated above, all services must be medically necessary, meaning those services are, "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." Additionally, "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." Here, Appellant has few case management needs because she has secured housing, benefits, and was engaged in therapy. Any continued assistance Appellant needs can be met through peer supports or community supports, as well as through her therapy, which is still authorized. Appellant was given adequate time to get peer and community supports in place with assistance from her case manager.

The burden is on Appellant to prove by a preponderance of evidence that 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 denied authorization for continued case management services for Appellant.

**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

cc: [REDACTED]

[REDACTED]  
Date Signed: January 10, 2014

Date Mailed: January 10, 2014

**\*\*\* 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.