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. 2014-24001 CMH
, **Case No.**

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 request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on . , Appellant's father, appeared and testified on Appellant's behalf. Appellant's mother; Appellant's Supports Coordinator; and Appellant's Behaviorist; were also present or testified on Appellant's behalf. Appellant was also present during the hearing, but did not participate. Assistant Corporation Counsel, represented Respondent (CMH). a Supervisor at the CMH's Access Center; a Director at the CMH's Access Center; and et, Hearings Officer; testified as witnesses for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for residential placement?

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 Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH's service area.

2. Appellant is who has been diagnosed with traumatic brain injury, intracranial hemorrhage, Factor II (Prothrombin) Deficient Hemophilia, Seizure Disorder, Intermittent Explosive Disorder, and Moderate Mental Retardation. (Respondent's Exhibit A, pages 10, 18-19, 30).

3. Appellant receives services through the CMH and, on or about , Appellant was admitted to the due to a substantial increase in aggressive and destructive behaviors. (Respondent's Exhibit A, page 19; Testimony of Appellant's representative).

4. The behaviors were occurring more than once daily and, given Appellant's actions and medical conditions, her parents were having difficulty managing her and therefore sought a higher level of care. (Respondent's Exhibit A, page 19).

5. The reports from provide in part that Appellant's aggressive or destructive behavior was much improved and stabilized during her placement, and that all her goals regarding tasks such as toileting training, brushing teeth, dressing, and sleeping had been met. (Respondent's Exhibit A, pages 20, 32-33; Testimony of Appellant's representative).

6. Per the Annual Assessment conducted by the CMH on , Appellant was expected to be discharged from to the family home on . (Respondent's Exhibit A, page 20).

7. On or about , Appellant was discharged from (Testimony of Appellant's representative).

8. Following that discharge, Appellant and her parents underwent an intensive crisis stabilization program over approximately the next three-and-a-half weeks. (Respondent's Exhibit A, pages 42, 55; Testimony of Appellant's representative).

9. Moreover, the CMH also authorized various home-based services, including supports coordination; medication review and evaluation; behavioral management services two times a week; community living supports (CLS) twenty-four hours a day; and eight overnight stays per month at the . (Respondent's Exhibit A, pages 19-21, 33, 36-40; Testimony of Dunton).

10. On , an Access Center Screening Report was generated in response to a request from Appellant's parents and Appellant's supports coordinator for residential placement. (Respondent's Exhibit A, pages 42-52).

11. During that request, Appellant's supports coordinator also reported that Appellant had recently increased her assaultive behavior in the home and engages in head punching, head banging, hitting, spitting, and property destruction. (Respondent's Exhibit A, page 42).

12. Appellant's supports coordinator also noted that, due to Appellant's hemophilia, her self-injuries put her at greater risk for further damage. (Respondent's Exhibit A, page 42).

13. The request for residential placement was forwarded on to the . (Respondent's Exhibit A, page 52).

14. That team reviewed the request and determined that it should be denied as the approved home-based services are more appropriate, efficacious, less-restrictive and cost-effective services that can also meet Appellant's medical needs. (Testimony of

15. On , the CMH sent Appellant written notice that the request for children's residential placement was being denied for the reason that "Consumer does not meet criteria for services requested." (Respondent's Exhibit A, page 6).

16. On , the CMH received a request for a Local Dispute Resolution (LDR). (Respondent's Exhibit A, page 54).

17. A LDR hearing was subsequently held before Valuet and, on , Valuet issued a decision upholding the CMH's actions. (Respondent's Exhibit A, pages 54-56).

18. On , the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf in this matter. (Respondent's Exhibit A, page 8).

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

Moreover, 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.

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.

Regarding medical necessity, the applicable version of the Michigan Medicaid Provider Manual (MPM) 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;

- 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;

  - 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.

MPM, January 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 12-14
(Underline added by ALJ)

Moreover, regarding the location of the provision of medically necessary services, the MPM states in part:

2.3 LOCATION OF SERVICE

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

For beneficiaries residing in nursing facilities, only the following clinic services may be provided:

- Nursing facility mental health monitoring;
- Psychiatric evaluation;
- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). The following mental health services initiated by the PIHP (the case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI. This should occur up to 60 days prior to the anticipated discharge from a CCI.
- Wraparound planning or case management. This should occur up to 60 days prior to discharge from a CCI.

> Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

MPM, January 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 9-10
(Underline added by ALJ)

Here, the sole issue on appeal is the denial of the request for residential placement for the minor Appellant. With respect to that issue, Appellant's representative bears the burden of proving by a preponderance of the evidence residential placement is a medical necessity in accordance with the Code of Federal Regulations and that the CMH erred in denying such placement in this case.

Given the record and evidence in this case, Appellant's representative has not met his burden of proof and the CMH's decision must be affirmed. Under the Department's medical necessity criteria section, there exists a more clinically appropriate, less restrictive and more integrated setting in the community for Appellant, specifically her own home. Clearly, Appellant's placement in her own home is less restrictive than any residential placement and the CMH justifiably relied on the reports from [redacted] when authorizing home-based services after Appellant was discharged from [redacted] Moreover, even if Appellant's representative is correct and the reports from [redacted] are inaccurate regarding the amount of progress Appellant has made in her abilities or behavior, he fails to demonstrate why Appellant cannot continue to work on her training and behavior in the home with the extensive home-based services authorized by the CMH, including behavioral management services two times a week; CLS twenty-four hours a day; and eight overnight stays per month at the [redacted].

Furthermore, as noted above, "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." Here, the CMH is authorizing extensive home-based services, and it is undisputed that the services were only in place for a short time when the request for residential placement was made. Given the short length of time services have been in place, it cannot be said at this time that this less restrictive level of treatment has been unsuccessful, especially where Appellant was transitioning from seven months in a residential placement.

The amount, scope and duration of the authorized services appears sufficient in this case and, while this Administrative Law Judge appreciates the difficulties Appellant and

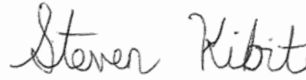
Appellant's family are having, the MPM still requires that services be provided in the least restrictive, most integrated setting possible, and Appellant's representative has failed to meet his burden of proving by a preponderance of the evidence residential placement is a medical necessity in accordance with the Code of Federal Regulations.

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 request for residential placement.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.



Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: _4/9/2014_

Date Mailed: _04/10/2014________

SK

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.