

**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. 2014-33068 CMH

██████████

██████████

██████████

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 ██████████. Appellant appeared and testified on his own behalf. ██████████, Assistant Corporation Counsel, represented Respondent ██████████ (CMH). ██████████, Director of the CMH's Access Center, testified as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's request for 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 people who reside in the CMH's service area.
2. Appellant is ██████ year-old male who has been diagnosed with Bipolar I Disorder. (Respondent's Exhibit A, page 24).
3. Appellant has been receiving services through the CMH since ██████, including targeted case management; medication reviews; and treatment planning. (Testimony of ██████).
4. On ██████████, the CMH's assessed Appellant's services. (Respondent's Exhibit A, pages 9-25).

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5. During that assessment, Appellant reported that he had been stable since being on his current medications and it was determined that he only wanted to continue his services in order to maintain an appropriate level of functioning. (Respondent's Exhibit A, page 15).
6. Appellant's services were reauthorized for another ███ months and, after that ███ month period, he requested another reauthorization of his services. (Testimony of ████).
7. On ████, the CMH sent written notice that it was denying the request for reauthorization of medication reviews on the basis that the "Consumer does not meet criteria for services requested." (Respondent's Exhibit A, page 5).
8. Similar notices were also issued with respect to Appellant's request for targeted case management and treatment planning. (Testimony of ████).
9. On ████ the Michigan Administrative Hearing System (MAHS) receiving the request for hearing filed in this case. (Respondent's Exhibit A, page 7).
10. In that request for hearing and in his testimony during the hearing, Appellant stated that he was very comfortable and happy with his current services and how they are provided, and that he does not want to go anywhere else. (Respondent's Exhibit A, page 7; Testimony of Appellant).

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

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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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

Regarding medical necessity, the applicable version of the 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.

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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*

In addition to requiring medical necessity, the MPM also makes a distinction between the responsibilities of CMHs and Medicaid Health Plans (MHPs):

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.

<p>In general, MHPs are responsible for outpatient mental health in the following situations:</p> <ul style="list-style-type: none">▪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	<p>In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:</p> <ul style="list-style-type: none">▪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
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<p>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.</p> <p><u>▪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.</u></p>	<p>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).</p> <p>▪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.</p> <p>▪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.</p>
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*MPM, January 1, 2014 version
Mental Health/Substance Abuse Chapter, page 3
(Underline added by ALJ)*

Here, the CMH determined that Appellant's request for a reauthorization of services must be denied as the services were no longer medical necessary and Appellant could have any mental health needs met through his MHP. In particular, its witness noted that

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Appellant reported being stable at the [REDACTED] assessment and that he continued to be stable after his services were reassessed six months later.

In response, Appellant testified that he was very comfortable and happy with his current services and how they are provided. He also testified that he does not want to go anywhere else for his needs and has not contacted his MHP regarding any available services.

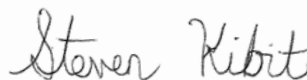
Based on the evidence presented, Appellant did not prove, by a preponderance of the evidence, that the denial of his request for reauthorization of services through the CMH was improper. The evidence shows that Appellant is stable and has been stable for over a [REDACTED] and, while Appellant is understandably very comfortable with his CMH service providers, that fact alone is not enough to overturn the Department's decision. The information available to the CMH at the time it determined he was not eligible for services showed he did not meet the eligibility criteria as the Appellant was not exhibiting severe psychiatric symptoms that were causing him significant impairment in his activities of daily living and Appellant also has health insurance through Medicaid which will cover medication review and therapy going forward. Appellant must therefore look to his MHP for any necessary 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 request for services.

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: [REDACTED]
Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

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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.