

**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. 2014-34828 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 her own behalf. ██████████, Fair Hearings Officer, represented Respondent ██████████ (CMH). ██████████, Utilization Manager, also 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. Appellant is a ██████ year-old Medicaid beneficiary who has been diagnosed with Major Depressive Disorder: Recurrent – Severe Without Psychotic Features. (Respondent's Exhibit A, pages 12, 40).
2. Appellant was previously enrolled in the Adult Benefits Waiver (ABW). (Testimony of ██████).
3. Mental health and substance abuse services for ABW beneficiaries were the responsibility of the Prepaid Inpatient Health Plans (PIHPs) and the Community Mental Health Services Programs (CMHSPs). (Medicaid Provider Manual (MPM), April 1, 2014 version, Adult Benefits Waiver Chapter, page 8).

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4. The CMH is one of those PIHPs/CMHSPs and Appellant was receiving weekly outpatient therapy through it. (Respondent's Exhibit A, page 6; Testimony of Appellant; Testimony of [REDACTED]).
5. Appellant's direct service provider was [REDACTED]. (Respondent's Exhibit A, page 6).
6. In a Progress Note dated [REDACTED], Appellant's outpatient therapist, wrote that she had discussed Appellant's past history with her, including past sexual abuse, and the difficulties that history was causing. [REDACTED] also recommended that Appellant start a journal. (Respondent's Exhibit A, pages 15-16).
7. In a Progress Note dated [REDACTED] wrote that Appellant was reporting intrusive thoughts relating to past sexual abuse, but had no thoughts of self-harm. They also explored Appellant hearing voices and exhibiting different personalities. [REDACTED] further noted that they discussed Appellant seeing a psychiatrist and that Appellant would see other outpatient therapists as needed when [REDACTED] was on vacation. (Respondent's Exhibit A, pages 17-18).
8. In the next Progress Note, dated [REDACTED] wrote that Appellant was doing well overall, but was continuing to have intrusive thoughts. She also wrote that they discussed Appellant's thoughts and explored techniques for stopping them, in addition to [REDACTED] validating the boundaries Appellant was setting with Appellant's mother. (Respondent's Exhibit A, page 20).
9. In a Progress Note dated [REDACTED] wrote that she and Appellant discussed Appellant's relationships with her family, stress related to those relationships, Appellant setting boundaries, and the family's resistance to such boundaries. (Respondent's Exhibit A, page 20).
10. Effective [REDACTED], the ABW ended and all beneficiaries enrolled in the ABW transitioned to specific health plans through the [REDACTED]. (MPM, April 1, 2014 version, Adult Benefits Waiver Chapter, page i).
11. Specifically, Appellant enrolled in [REDACTED]. (Testimony of Appellant; Testimony of [REDACTED]).
12. In a Progress Note dated [REDACTED] wrote that she and Appellant explored Appellant seeing another therapist in order to try Eye Movement Desensitization and Reprocessing (EMDR) therapy. They also reviewed Appellant's skills and techniques for working through anxiety and

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setting boundaries with her family. (Respondent's Exhibit A, pages 23-24).

13. In a Progress Note dated ██████████, another outpatient therapist, wrote that she met with Appellant and discussed Appellant's past history. ██████████ also began educating Appellant on EMDR and they scheduled Appellant's next two appointments. (Respondent's Exhibit A, page 25).
14. On ██████████ drafted a Treatment Plan Meeting/Review of Progress report. (Respondent's Exhibit A, pages 12-14).
15. In that document, ██████████ identified one treatment goal implemented in ██████████, "[Appellant] will report an improvement in feelings of self worth" and the medical necessity for that goal as:

Client has been experiencing increased depression and anxiety. She recently moved back to ██████████ and conflict within the family is causing her significant stress. History of childhood abuse.

Respondent's Exhibit A, page 12

16. The first objective within that general goal was for Appellant to "process memories of childhood trauma and reframe negative beliefs." (Respondent's Exhibit A, page 12).
17. With respect to that objective, ██████████ noted that Appellant had discussed the trauma, but was having difficulty processing it at times and ██████████ had referred her for EMDR. (Respondent's Exhibit A, page 12).
18. ██████████ also wrote that the first objective should continue as written. (Respondent's Exhibit A, page 12).
19. The second objective within Appellant's general goal was for Appellant to "make a pros and cons list related to cutting family out of her life". (Respondent's Exhibit A, page 12).
20. With respect to that objective, ██████████ noted that Appellant had recently begun limited conversations with her mother and had set boundaries with her sisters as well. (Respondent's Exhibit A, page 12).
21. ██████████ also wrote that the second objective should continue as written. (Respondent's Exhibit A, page 12).

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22. The third objective within Appellant's general goal was for Appellant to "learn at [sic] five coping skills to deal with stress, trauma, and negative emotions." (Respondent's Exhibit A, page 13).
23. With respect to that objective, ██████████ noted that Appellant continues to remain receptive to coping skills and is doing well in school. (Respondent's Exhibit A, page 13).
24. ██████████ also wrote that the third objective should continue as written. (Respondent's Exhibit A, page 13).
25. On ██████████ also requested that Appellant continue with services through the CMH rather than having Appellant's mental health services transitioned to Appellant's new health plan. (Respondent's Exhibit A, page 6).
26. In making that request, ██████████ noted:

[Appellant] has a significant trauma history including being sexually abused by family members when younger. She also has a history of substance dependence, sexual addiction, and overall limited insight and difficulties with emotion regulation. She is also estranged from family, poor interpersonal effectiveness. Her significant needs and inability to meet these needs in 20 sessions makes her a type 21.

Respondent's Exhibit A, page 6

27. The CMH reviewed that request and determined that it should be denied because Appellant's needs could be met by her health plan given that Appellant was not exhibiting any functional impairment; was not taking any medications; was going about her daily life and doing well in school; and had achieved significant growth through therapy. (Respondent's Exhibit A, page 6; Testimony of ██████████)
28. On ██████████, the CMH sent Appellant written notice that her request for services was denied. (Respondent's Exhibit A, pages 8-10).
29. Regarding the reason for the denial, the notice stated:

You don't meet criteria for specialty health services as you aren't experiencing significant

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difficulty functioning in your daily life, or there are no concerns related to your safety safety [sic] due to mental health issues. You can continue to see a therapist at [REDACTED] through your [REDACTED].

Respondent's Exhibit A, page 8

30. On [REDACTED], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Respondent's Exhibit A, page 11).

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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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.*

In addition to requiring medical necessity, the Medicaid Provider Manual (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

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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 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.	<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 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
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	purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.
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MPM, April 1, 2014 version
Mental Health/Substance Abuse Chapter, page 3

Here, the CMH determined that Appellant's request for a reauthorization of services must be denied as services through the CMH were no longer medical necessary as Appellant could have her mental health needs met through her MHP. In particular, its witness noted that Appellant can continue to see the same therapist at [REDACTED] through her [REDACTED] and was not exhibiting any functional impairment, taking any medications, or exhibiting any safety concerns due to any mental health issues. [REDACTED] also testified that the available information instead demonstrated that Appellant was going about her daily life, doing well in school; and had achieved significant growth through therapy.

In response, Appellant testified that she did not like her old therapist, [REDACTED], and therefore did not tell her everything. She also testified that, while she has had a slight improvement with her therapy, she still has difficulty sleeping and is always stressed. Appellant further testified that she has not sought services through her MHP.

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying her request for services. Moreover, the undersigned Administrative Law Judge's jurisdiction is limited to reviewing the CMH's decision in light of the information it had at the time it made that decision.

Based on the available evidence in this case, Appellant failed to demonstrate by a preponderance of the evidence that the CMH erred in denying the request for reauthorization of services through the CMH or in finding that her needs could be met through her MHP.

Appellant was previously authorized for weekly outpatient therapy and, despite months of such weekly therapy, her Appellant's former outpatient therapist still found that Appellant's significant needs and her inability to meet those needs in 20 sessions per year justified services through the CMH. However, the progress notes documenting the course of Appellant's therapy does not reflect any significant needs, serious impairments, or severe current symptoms. Instead, those brief notes demonstrate that while Appellant is still working on issues relating to past trauma and current relationships, she is also doing well in school and her daily life.

Moreover, while Appellant now testifies that she failed to report all her needs or issues to her old therapist, the CMH must rely on the information it has and, as discussed above, the undersigned Administrative Law Judge's jurisdiction is limited to reviewing the CMH's decision in light of the information it had at the time it made that decision.

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Here, the information available to the CMH at the time it determined Appellant was not eligible for services showed she did not meet the eligibility criteria as the Appellant was not exhibiting severe psychiatric symptoms that were causing her significant impairment in her activities of daily living and Appellant also has health insurance through Medicaid which will cover therapy going forward. Appellant must therefore look to her MHP for any necessary services.

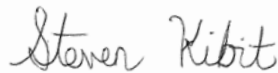
To the extent Appellant has new or additional information to provide, her circumstances change, or it is determined that her need for therapy exceeds the 20-visit maximum for the calendar year through the MHP, she can always re-request services through the CMH in the future. With respect to the decision at issue in this case, however, the CMH's decision must be affirmed given the information available at the time.

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]

***** 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.