

**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. 2014-35369 CMH

██████████,

██████████

██████████

Appellant

_____ /

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a telephone hearing was held ██████████ Appellant appeared and testified on his own behalf.

██████████, Fair Hearings Officer, appeared and testified on behalf of ██████████ Community Mental Health (CMH), representing the Department. ██████████ Utilization Manager as a witness for the Department.

ISSUE

Does the Appellant meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH?

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 Appellant is a ██████ year-old male (██████████) Medicaid beneficiary. (Exhibit A, pp. 1, 6, 14, 18 and testimony).
2. CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.
3. CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.
4. Appellant has been diagnosed with Mood Disorder, NOS, and was receiving Outpatient Therapy Services and had been approved for Psychiatric Services through CMH that were terminated before Appellant could be seen by a

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psychiatrist. Appellant was transitioned to Healthy Michigan Priority Health Insurance effective [REDACTED] as the ABW plan was no longer available to such beneficiaries. (Exhibit A, p.1 and testimony).

5. On [REDACTED], LMSW, ACSW, Utilization Manager for CMH received a request from [REDACTED] Appellant's therapist at [REDACTED] [REDACTED] requesting that the Appellant be switched to "Type 21" status. (Exhibit A, pp. 1 6-7 and testimony).
6. On [REDACTED] issued two negative Action Notice denying Psychotherapy and Outpatient Therapy Services effective [REDACTED]. The reason for the denials was that the Appellant was not having severe psychiatric symptoms and did not meet the eligibility criteria for Specialty Mental Health Services through CMH. (Exhibit A, pp. 1, 8-11 and testimony).
7. On [REDACTED], Appellant filed local appeals with CMH. (Exhibit A, pp. 12-13).
8. On [REDACTED], Chief Clinical Director for CMH upheld the denials for Psychotherapy and Outpatient Therapy Services stating that Appellant's clinical records do not show that he has a chronic and severe mental illness and that he should seek services under his new Healthy Michigan Priority Health Insurance Plan. (Exhibit A, pp. 14-15).
9. On [REDACTED] MAHS received the Appellant's requests for an Administrative Hearing. (Exhibit A, pp. 16-17).

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].

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—

Under approval from the Center for Medicaid and Medicaid Services (CMS) the Michigan Department of Community Health (MDCH) operates a section 1915(b) waiver called the Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the MDCH to provide services under the Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. CMH must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, amended, and those services/supports included as part of the contract between the Department and CMH.

██████████ LMSW, ACSW, Utilization Manager for CMH, stated that on ██████████ she received a request from ██████████ Appellant's therapist at ██████████ requesting that the Appellant be switched to "Type 21" status. ██████████ stated she reviewed the Appellant's clinical records and found that the available information did not indicate how the Appellant's symptoms were affecting his ability to perform his activities of daily living. Despite indicating suicidal and homicidal ideation, there was no evidence of any plans to carry out or follow through with these ideations. ██████████ stated according to Appellant's treatment plan and his progress notes the Appellant did not exhibit the severe psychiatric symptoms necessary to meet the eligibility criteria for services through CMH. Accordingly, ██████████ issued two negative Action Notice denying Psychotherapy and Outpatient Therapy Services effective ██████████. The reason for the denials was that the Appellant was not having severe psychiatric symptoms and did not meet the eligibility criteria for Specialty Mental Health Services through CMH. (See Exhibit A, pp 8-11).

On ██████████ Appellant filed local appeals with CMH. On ██████████ ██████████ Chief Clinical Director for CMH upheld the denials for Psychotherapy and Outpatient Therapy Services finding that the Appellant's clinical records did not show that he had a chronic and severe mental illness and, therefore, he should seek services under

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his new Healthy Michigan Priority Health Insurance Plan. (See Exhibit A, pp. 14-15).

This Administrative Law Judge does not have jurisdiction to order the CMH to provide Medicaid covered services to a beneficiary who is not eligible for those services. This Administrative Law Judge determines that the Appellant is not eligible for CMH Medicaid covered services for the reasons discussed below.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6* makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid specialized ambulatory mental health benefits. The Medicaid Provider Manual provides:

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"><input type="checkbox"/> 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.	<p>In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:</p> <ul style="list-style-type: none"><input type="checkbox"/> 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,
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<p><input type="checkbox"/> 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). <u>The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</u></p>	<p>communicative or adaptive skills).</p> <p><input type="checkbox"/> 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><input type="checkbox"/> 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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[*Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section*, April 1, 2014, page 3].

The CMH must follow the Department's Medicaid Provider Manual when approving mental health services to an applicant, and the CMH must apply the medical necessity criteria found within the Medicaid Provider Manual. The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Medical Necessity Criteria*, Section 2.5, April 1, 2014 lists the criteria the CMH must apply as follows:

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services and treatment:

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- 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;

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- 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;
 - 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. [pp. 12-14].

Appellant testified he needs help in a major way. He said he needs help coping with life in general. He is not himself anymore and has trouble dealing with his children and can't associate with the people around him. Appellant said he would like to do the sessions of outpatient therapy available through the Healthy Michigan Priority Health Insurance Plan.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid Covered mental health services and properly determined he was

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not. 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. Furthermore, he could obtain additional psychotherapy services through his new Medicaid benefit the Healthy Michigan Priority Health Insurance Plan.

The testimony of the Appellant does not change the previous decision of CMH. Appellant did not establish that he was suffering from severe psychiatric symptoms which would qualify him for services through CMH. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly determined that the Appellant does not meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH.

IT IS THEREFORE ORDERED THAT:

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

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]
Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health 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.

