STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 14-014620 CMH
[redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. Appellant appeared and gave testimony on his own behalf.

[redacted], Fair Hearings Officer, appeared and testified on behalf of [redacted] Community Mental Health (CMH), and represented the Department. [redacted], LMSW, ACSW, Utilization Manager also appeared as a witness for the Department.

ISSUE

Did the CMH properly deny Appellant's request for Targeted Case Management and 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 Appellant is a Medicaid beneficiary who had been receiving Case Management, Psychiatric, and Psychotherapy services. (Exhibit A, p. 1 and testimony).

2. [redacted] is the Community Mental Health contractor with the State of Michigan, (hereinafter CMH).

3. On [redacted], CMH issued an Action Notice denying Appellant's, request for Case Management services based on a finding that the Appellant's needs for case management services had been met and his symptoms of increased depression and anxiety can be met with his Psychiatric and Psychotherapy services. (Exhibit A, pp. 1, 6-8 and testimony).

4. On [redacted], Appellant's request for hearing was received by MAHS. (Exhibit A, pp. 11-12).

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*].

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. 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.

The witnesses for CMH, [redacted], Customer Service Specialist and Fair Hearings Officer, and [redacted], LMSW, ACSW, Utilization Manager provided reliable evidence that the Appellant had been receiving Case Management, Psychiatric, and Psychotherapy services. On [redacted] CMH issued an Action Notice denying Appellant's, request for Case Management services based on a finding that the Appellant's needs for case management services had been met and his symptoms of increased depression and anxiety can be met with his Psychiatric and Psychotherapy services.

[redacted] stated she was familiar with Appellant's clinical records relating to his CMH services. She stated she received his request for case management services and reviewed his assessment, his treatment plan, and his quarterly therapy reviews. [redacted] specifically stated all of the Appellant's needs for case management services had been met. [redacted] referred to the Appellant's treatment plan, (see Exhibit A, p. 15), and demonstrated that the goals and objectives for the Appellant's case management services set forth in his treatment plan had been met. Documentation in his clinical record shows the Appellant had obtained Medicaid, SSI/SSD and Medicare, there was no evidence that attendance at his psychiatric appointments had been a problem, or that compliance with taking medications had been an issue, and the Appellant was appropriately engaged in therapy which is the proper service to address his mental health issues.

[redacted] also acknowledged the Appellant's claim in his request for hearing that he needed his case manager to help him remember the instructions given by his psychiatrist [redacted] pointed out the doctor's instructions are available to the Appellant's therapist [redacted] in their computerized files, and his therapist would be able to give the Appellant further assistance with his doctor's instructions and any prescribed medications. The witnesses for CMH noted that the Appellant's future needs for assistance with housing or other community resources could be met by contacting [redacted], requesting resource assistance through his therapist, or [redacted] benefit specialists.

Medicaid beneficiaries are entitled to receive medically necessary Medicaid covered services. 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*. CMH is required to use a person-centered planning process to identify medically necessary services and how those needs would be met pursuant to its contract with the Department of Community Health. The person-centered planning process is designed to provide beneficiaries with a "person-centered" assessment and planning in order to provide a broad, flexible set of supports and services. Medically necessary services are generally those identified in the Appellant's person-centered plan or IPOS.

The *Medicaid Provider Manual* defines terms in the *Mental Health/Substance Abuse Section*, dated October 1, 2014. It defines medical necessity as follows:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services. [*Medicaid Provider Manual, Mental Health /Substance Abuse,* October 1, 2014, p. 5].

The *Medicaid Provider Manual* further specifies Medical Necessity Criteria:

> **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/aids) who know the beneficiary; and
> - Based on clinical information from the beneficiary's primary care physician or health care professions with relevant qualifications who have evaluated the beneficiary; and
> - For beneficiaries with mental illness or developmental disabilities, based on personal-centered planning, and for beneficiaries with substance use disorders, individuals 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.

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 the 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. In patient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or supports 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, fate-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. [*Medicaid Provider Manual, Mental Health/Substance Abuse Section,* October 1, 2014, pp. 12-14].

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, §13 Targeted Case Management* provides for the authorization of case management services for individuals such as the Appellant. It states in part:

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.

*** * ***

13.2 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.
- 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. [pp. 82-83].

The Appellant testified he wants to keep getting help from his case manager [redacted]. Appellant said with his dad dying he and his mother are not going to be able to keep their house, so he wants help from his case manager to assist him with getting new housing. Appellant said he is bipolar. He said his doctor thinks he should have a case manager, and his case manager believes he is still needed. Appellant said that his case manager has been there whenever he has needed him. Appellant said his records do not show the peace of [redacted] he gets from having his case manager there to help him. Appellant said his case manager has filled out everything for him. He said he has a learning disability and can't read or spell. He said he has taken [redacted] different medications and had reactions to them. Appellant said he has had some problems with his Medicaid eligibility and needs help with this from his case manager. He also said that he used to be a mortgage closer.

The credible and persuasive evidence of record demonstrates that the Appellant's current functional status is such that his needs can be met with his ongoing Psychiatric and Psychotherapy services. Appellant's future needs for assistance with housing or other community resources could be met by him contacting [redacted], requesting resource assistance through his therapist, or [redacted] benefit specialists.

This ALJ concurs with the Department's determination that the Appellant does not require case management services. Medical necessity has not been shown to exist for the requested case management services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] CMH services properly denied Appellant's request for case management services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed : [redacted]

Date Mailed: [redacted]

WDB/db

cc: [redacted]

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 Administrative Tribunal 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.