STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF

Docket No. 15-004429 CMH
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

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

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

[redacted], Customer Services Representative, [redacted], (formerly [redacted] Community Mental Health) represented the Department ([redacted] or CMH). [redacted], Supports Coordinator; [redacted], Supports Coordinator Supervisor; and [redacted], Therapist, appeared as witnesses for [redacted].

ISSUE

Did [redacted] properly terminate Appellant's 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 [redacted] year-old Medicaid beneficiary, born [redacted], who has been receiving services through [redacted] (Exhibit 2, p 5; Testimony)

2. Appellant is diagnosed with bipolar II disorder, poly-substance dependence, antisocial personality disorder, hypertension, post-myocardial infarction and gastro esophageal reflux disorder (GERD). Appellant is allergic to bee-stings, Flexeril, Penicillin and Robaxin. Appellant has economic problems and problems related to his social environment. (Exhibit 3, p 17; Testimony)

3. Appellant was receiving supports coordination services, outpatient therapy, and medication reviews through [redacted]. (Exhibits 3-6; Testimony)

4. On [redacted], [redacted] sent Appellant an Adequate Action Notice informing him that his services were being terminated because Appellant informed his supports coordinator that he no longer needed services. (Exhibit 3, pp 15-16; Testimony)

5. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. In his request for hearing, Appellant indicated that he never requested that his services be terminated; he simply requested a new supports coordinator. (Exhibit A)

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 Health and Human Services (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Health and Human Services 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 Department's *Medicaid Provider Manual, Mental Health and Substance Abuse Section, Medical Necessity Criteria, Section 2.5* makes the distinction that it is the CMH responsibility to determine Medicaid outpatient mental health benefits based on a review of documentation. The Medicaid Provider Manual sets out the medical necessity eligibility requirements, in pertinent part:

> **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. MEDICAL NECESSITY 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; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized 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.
- Documented in the individual plan of service.

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.
>
> *Medicaid Provider Manual*
> *Mental Health and Substance Abuse Section*
> *January 1, 2015, pp 12-14*

Appellant's supports coordinator testified that Appellant told her during a phone conversation that he no longer needed her services and could get all of the services he needed through his primary care physician and therapist. Appellant's supports coordinator indicated that she then did not hear from Appellant for approximately 30 days so she checked with her supervisor, who informed her to terminate Appellant's services.

Appellant's therapist testified that Appellant was making progress in therapy and he would be glad to work with him again.

Appellant testified that he believes his case was closed because he asked for a new supports coordinator. Appellant indicated that several people at [redacted] knew he wanted a new supports coordinator. Appellant testified that he would happy if services could be reinstated. Appellant indicated that there is nothing in the supports coordinator's notes indicating the he said he wanted his case closed. Appellant indicated that his primary care physician will not prescribe him Depakote and told him that it must be prescribed by a psychiatrist. Appellant also agreed that he was making headway in therapy.

Appellant must prove by a preponderance of evidence that the termination of his services was improper. Based on the evidence presented, Appellant was unable to do so. Clearly, there is a difference of opinion between Appellant and his supports coordinator as to whether Appellant indicated that he no longer needed services through [redacted]. However, there is evidence in the record that Appellant got upset with his supports coordinator and then called back later to apologize. It seems more likely than not that in the present case Appellant became upset and then called and told his supports coordinator that he no longer needed services. Appellant's supports coordinator waited for a period of time and, having not heard from Appellant, spoke to

her supervisor, who concurred that Appellant's case should be closed. As such, [redacted]'s decision must be upheld.

Appellant can always reapply for services through [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

[redacted]'s termination of Appellant's services was proper.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

cc: [redacted]

RJM[redacted]

Date Signed: [redacted]

Date Mailed: [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.