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. 15-005595 CMH

[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] LBSW, Appellant's Case Manager with [redacted] appeared and gave testimony on the Appellant's behalf. Appellant was present but declined to testify.

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

ISSUE

Did the CMH properly deny Appellant's request for Outpatient Therapy (OPT) 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 Medicaid beneficiary who has been diagnosed with Schizophrenia, undifferentiated type, situational depressive disorder, NOS, and alcohol dependence. He is authorized to receive Case Management and Psychiatric Services through CMH provided by their contractual provider [redacted]. (Hearing Summary, p. 1, Exhibits F, p. 4, G, p. 4, H, p. 4, I, p. 4, J, pp. 24-25 and testimony).

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

3. On [redacted], CMH received a request for Outpatient Therapy (OPT) on the Appellant's behalf from their contractual provider [redacted]. (Hearing Summary, p. 1, Exhibit B and testimony).

4. On [redacted], LMSW, ACSW, Utilization Manager issued a Negative Action Notice denying Appellant's, request for OPT based on a finding that mental health therapy is not considered the best practice for a diagnosis of Schizophrenia. Also [redacted] stated the Appellant's depression was situational and could be improved working with his case manager and linking with community resources. [redacted] recommended treatment for the Appellant's substance abuse, noting his case manager could assist with linking the Appellant with substance abuse therapy and/or substance abuse support groups in the community. (Hearing Summary, p. 1, Exhibit D, pp. 1 and testimony).

5. On [redacted], Appellant's request for hearing was received by MAHS. (Exhibit E).

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 (MDHHS) 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 witness for CMH, [redacted], LMSW, ACSW, Utilization Manager provided reliable evidence that the Appellant does not meet the criteria for Outpatient Therapy (OPT) through CMH. [redacted] stated there was a request for OPT for the Appellant on [redacted] said she denied the service at that time and issued a Negative Action Notice because therapy is not considered the best practice for Schizophrenia. She said his depressive diagnosis was not otherwise specified, and is not considered a major mental illness. [redacted] also noted a tertiary diagnosis of alcohol dependence. [redacted] said in making her determination she looked at the Appellant's medication reviews. (Exhibits F-I and testimony).

[redacted] noted that in [redacted] Appellant reported he was trying to become more active by signing up for computer classes and attending church, but had relapsed back into heavier alcohol use. [redacted] did not find that the Appellant had significant functional impairment based on the January medication review. [redacted] reviewed a [redacted] medication review which indicated the Appellant wasn't doing well due to an eviction from his apartment and having to live with his son-in-law which had been stressful because his son-in-law did not tolerate any alcohol use. [redacted] noted, however, that the Appellant's living arrangement has now changed and she found that the Appellant's depression was situational and that the Appellant's condition did not meet the criteria for receiving OPT through CMH. Appellant's latest medication review indicated the Appellant was doing better and his mood had improved, he was sleeping better and was more interested in doing things. (See Exhibit I).

[redacted] stated her recommendation for assisting the Appellant was for him to utilize depression support groups in the community to learn skills to deal with his depression. She also stated if the Appellant is experiencing increased substance abuse, he could receive therapy for his substance abuse through local community resources. [redacted] concluded that medical necessity is not met in this case for the Appellant to receive OPT through

CMH. [redacted] stated that the information she reviewed in making her determination that he did not meet medical necessity criteria from his medication reviews showed that the Appellant was functioning fairly well in his daily life and did not have a serious mental illness.

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.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
□ 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	□ 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

performance, etc.) and minimal clinical (self/other harm risk) instability.	maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).
☐ 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.	☐ 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 purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

[*Medicaid Provider Manual, Mental Health and Substance Abuse, §1.6 Beneficiary Eligibility Section,* January 1, 2015, p. 3].

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 January 1, 2015. 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,* January 1, 2015, 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,* January 1, 2015, pp. 12-14].

The Appellants' Case Manager testified that the statements made by the Appellant that [redacted] referred to in the medication review notes, were made by the Appellant but without any follow through. The Case Manager said the Appellant's depression becomes isolative and therefore he doesn't follow through with his stated intentions. The Case Manager said the Appellant had utilized substance abuse services and a support group in the past that was successful for a short period, but the Appellant's situation has continued for a couple of years and he continues to present with his depressive symptomology. Appellant's Case Manager said that they have the outpatient services at [redacted] that the Appellant has requested with therapists who have substance abuse credentialing. He concluded by saying that there therapist could address both the Appellant's depression and substance abuse issues which he thought would be more effective for the Appellant's future health.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant met the criteria for OPT through CMH and properly determined that he did not. The information available to the CMH at the time it determined the Appellant was not eligible for outpatient therapy showed he did not meet the medical necessity criteria for receiving the requested services. It was determined that the requested OPT was not the best practice for treating the Appellant's diagnosis of schizophrenia. The Appellant's clinical records showed that he did not have a serious mental illness, his diagnosis of depressive disorder, NOS, is not considered a major mental illness, and finally, the information contained in his medication reviews indicated that his depression was situational, and he appeared to be functioning fairly well in his daily life. Finally, [redacted] was able to identify other appropriate, efficacious, less-restrictive and cost-effective services available in the community that would meet the Appellant's need for services.

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

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 outpatient therapy.

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 Health and Human Services

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.