STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-020558 CMH
Agency Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. [redacted], Mother, represented Appellant. [redacted], Aunt and Caregiver, appeared as a witness for Appellant. [redacted], Assistant Corporation Counsel, represented [redacted] County Community Mental Health ("CMH" or "Department"). Dr. [redacted], Licensed Psychologist and Clinical Supervisor [redacted], appeared as a witness for the CMH.

ISSUE

Did the CMH properly deny Appellant's requests for authorization for retroactive 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 who has been diagnosed with borderline intellectual functioning and hypotonia. (Department Exhibit C, p. 13)

2. Appellant's CMH services include respite, community living supports, fiscal intermediary services, supports coordination, and assessments. (Department Exhibit A, pp. 4-9)

3. On [redacted], and [redacted], the CMH [redacted] received requests to authorize services for Appellant effective [redacted]. (Pre-Hearing Summary pp. 1-2; Testimony of CMH witnesses)

4. On [redacted], and [redacted], the CMH issued denial notices to Appellant because the Access Center can only authorize services prospectively. Requested services were authorized effective [redacted], and [redacted]. (Department Exhibit A, pp. 4-9)

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Department Exhibit B, p. 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 statutes, 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*

Additionally, 42 CFR 430.10 states:

> 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 also 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…

42 USC 1396n(b)

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 (DHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

The CMH contracts with DHHS to provide services pursuant to its contract with the Department and eligibility for services through it is set by Department policy, as outlined in the Medicaid Provider Manual (MPM).

The MPM addresses PIHP decisions and prior authorization:

> **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;
> - that are 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.
>
> *MPM, October 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, page 14*
> *(Exhibit C)*

Further, the CMH has adopted a policy requiring prior authorization, except an emergency situation. (Exhibit E, pp. 17-30) In part, the admission criteria states "prior approval for continued stay in a level of care, or for a change in level of care, is also required thought he [redacted]." (Exhibit E, p. 23)

On [redacted], and [redacted], the CMH [redacted] received requests to authorize services for Appellant effective [redacted]. (Pre-Hearing Summary pp. 1-2; Testimony of CMH witnesses)

On [redacted], and [redacted], the CMH issued denial notices to Appellant because the [redacted] can only authorize services prospectively. Requested services were authorized effective [redacted], and [redacted]. (Department Exhibit A, pp. 4-9)

The testimony from Appellant's mother indicated that [redacted] had been providing Supports Coordination services for Appellant. Appellant's previous authorization period for all services expired at the end of [redacted]. It appears that there was a staffing turnover/shortage and Appellant was without a Supports Coordinator for a while. Appellant's mother made many calls and could not reach anyone at [redacted]. Accordingly, no Supports Coordinator or other contact from [redacted], ensured that a new services authorization was in place before the expiration of the previous authorization at the end of [redacted] Eventually, a new Supports Coordinator was provided for Appellant and a home visit was completed. The new Supports Coordinator told Appellant's mother that she would have the new authorization backdated to [redacted]. Appellant's mother also confirmed that the actual care services were provided to Appellant during the retroactive period. Timesheets were filled out and Appellant's mother asserts that the Appellant's caregiver should be paid for her services. (Mother Testimony)

The Clinical Supervisor Access Center testified that even when a services authorization lapses, the [redacted] cannot authorize services for a retroactive period. Rather, the [redacted] can only authorize services prospectively. The Clinical Services Supervisor testified that the Supports Coordinator should enter the authorization in prior to the start of services. (Clinical Supervisor [redacted] Testimony)

Appellant bears the burden of proving by a preponderance of the evidence that the CMH erred in denying the retroactive services requests. Appellant has met that burden. The policy is clear that under the above cited MPM policy, the CMH may utilize a prior authorization process to determine the amount, scope, and duration of services. However, in this case it was the CMH contractor, [redacted], that failed to timely complete their home visit and assessment to request prior authorization for the new services authorization period before the previous authorization period expired. Accordingly, the CMH's determination to deny the retroactive periods for the services requests, and only approve services as of the date the [redacted] received the services requests, cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH improperly denied Appellant's requests for authorization for retroactive services.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED**. The CMH shall re-consider the [redacted], and [redacted], services requests for the retroactive periods and issue a determination based on medical necessity.

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

CL[redacted]

Date Mailed: February 2, 2016

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.