STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 15-009917 CMH

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 hearing.

After due notice, a telephone hearing was begun on Appellant appeared and testified on his own behalf. Regional Customer Services Specialist, appeared and testified on behalf of Respondent , Clinical Specialist, and , Senior Outreach Team Leader, also testified as witnesses for Respondent.

During the telephone hearing, Appellant was disconnected from the conference call. The undersigned Administrative Law Judge called Appellant multiple times thereafter, but there was no answer and the hearing could not be completed that day. Accordingly, the undersigned Administrative Law Judge ordered that the hearing be continued and the parties were notified that a continued hearing would be held on .

The continued hearing was held on as scheduled. Appellant again appeared and testified on his own behalf. The same participants as before were also present for Respondent. The hearing in this matter was completed on that day and the record closed.

ISSUE

Did properly deny Appellant's request for a reauthorization of 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 year-old Medicaid beneficiary who has been diagnosed with Anxiety Disorder NOS; Bipolar I Disorder; Alcohol

Dependence; Opioid Dependence; and Personality Disorder NOS. (Exhibit 2, pages 11-12; Exhibit 20, page 9).

2. Due to other physical conditions, Appellant also has severe chronic pain in his back, abdomen, feet, and legs. (Exhibit 2, page 6; Testimony of Appellant).

3. Appellant has been receiving mental health services through [redacted] for years and has progressed through [redacted] program, which Appellant was in until [redacted], which Appellant was in until [redacted] and [redacted] Program, which Appellant was in until [redacted] (Exhibit 2, pages 1-2).

4. In the [redacted], Appellant was authorized to receive individual therapy, case management, psychiatric services, and nursing services. (Exhibit 4, page 1; Testimony of [redacted] Clinical Specialist).

5. However, by [redacted], Appellant had not been engaging in his individual therapy for months and he was no longer interested in receiving it. (Exhibit 3, pages 3-34; Testimony of Appellant).

6. Appellant continued to utilize the approved psychiatric services and the pain medications he was prescribed through it. (Exhibit 3, pages 3-34).

7. During that time, Appellant was also being prescribed pain medications through both his primary care physician (PCP) and doctors at the [redacted] (Exhibit 3, pages 3-34).

8. Appellant would not always take some of the medications that were prescribed; would request increased amounts of others medications; and would frequently change medications and doctors when he was not prescribed what he wanted. (Exhibit 3, pages 3-34).

9. Appellant reportedly kept track of his medications himself through his own system and the use of a notebook, despite concerns expressed by [redacted] regarding his system. (Exhibit 3, pages 14-15, 23-24, 29-30).

10. By [redacted] determined that Appellant's services through it should end and he should be discharged as he was not engaged in his therapy sessions; the psychiatric services he was interested in could be provided at the [redacted], where he has received psychiatric and medical services for years; and Appellant could also receive any necessary substance abuse services at the [redacted] as well. (Exhibit 3, pages 1-3).

11. found Appellant to be receptive to a discharge at that time and assisted him in scheduling an appointment with the . (Exhibit 3, pages 1-3).

12. On , Respondent sent Appellant advance written notice that his services through it were being terminated. (Exhibit 4, pages 1-3).

13. On the Michigan Administrative Hearing System (MAHS) received a request for hearing filed by Appellant with respect to that termination. (Exhibit 5, pages 1-2).

14. MAHS docketed Appellant's case as 15-003349 CMH and scheduled a hearing for (Exhibit 6, page 1).

15. While that case was pending, Appellant also filed a local appeal with . (Exhibit 7, pages 1-3).

16. Through that local appeal, Appellant and Respondent resolved this matter and he subsequently sent MAHS a signed withdrawal of his request for hearing. (Exhibit 8, page 1).

17. That signed withdrawal indicated that Appellant was withdrawing because the parties had agreed to a short-term reauthorization of services through while Appellant was linked to other services. (Exhibit 8, page 1).

18. Based on that withdrawal, Docket No. 15-003349 CMH was dismissed. (Exhibit 9, page 1).

19. then attempted to set up an Interim Person-Centered Plan meeting with Appellant, but, despite appointment reminders being sent to him, Appellant failed to show for meetings on and or otherwise contact (Exhibit 11, pages 1-4; Exhibit 12, pages 1-2; Exhibit 13, pages 1-3).

20. Appellant was in the hospital on due to abdominal pain, and a psychiatric consultation was completed during that hospitalization after Appellant reported that he wanted to die because of his physical pain. (Exhibit 16, pages 1-4).

21. On sent Appellant written notice that his request for reauthorization of services was denied as the clinical documentation did not establish medical necessity for services. (Exhibit 1, pages 1-2).

22. Specifically, the notice also provided:

> Your services requested through has [sic] been denied. You no

> longer meet medical necessity criteria for specialty mental health services through [redacted], as you do not have a severe and persistent mental illness. At this time, your mental health symptoms are not of a severe level of intensity. Further, we have attempted on numerous occasions to meet with you to facilitate referrals to community agencies that could more appropriately meet your needs as part of our discharge planning. You did not show nor call to cancel the three appointments that have been arranged to link you to those agencies. At this time, your plan of service expired effective J[redacted]. As such, we are closing your case at [redacted]. We encourage you to contact the agencies on the resource list attached to this mailing for services.

Exhibit 1, page 1

23. On [redacted], MAHS received the request for hearing filed by Appellant in this matter regarding that action. (Exhibit A, pages 1-6).

24. With due notice, a hearing was then scheduled for [redacted]. (Exhibit 20, page 8).

25. While the appeal was pending, on or about [redacted], Appellant was sent by his PCP to the hospital because of his pain. (Exhibit 16, page 14).

26. At the hospital, Appellant was cleared and no pain medications were ordered, despite Appellant's request for them. (Exhibit 16, page 14).

27. A mental health evaluation was ordered at the time after Appellant, upon being told that no pain medications were being ordered, stated that he was going to go home and shoot himself and die. (Exhibit 16, page 14).

28. [redacted] then performed an emergency screening. (Exhibit 16, pages 5-15).

29. During the screening, Appellant said that he is just tired of the pain, he does not own or have access to a gun, he does not want to die, and that he has not had any delusions or hallucinations. (Exhibit 16, page 14).

30. Appellant also denied any mental health issues and he only wanted to discuss his pain. (Exhibit 16, page 14).

31. He also reported that he was not interested in outpatient services at the [redacted] and just wanted pain pills. (Exhibit 16, page 14).

32. The screener contacted Appellant's PCP, who indicated that he had wanted Appellant admitted due to the inability to control pain and that working with a psychiatrist would best meet Appellant's needs. (Exhibit 16, page 15).

33. The screener also spoke with the emergency department doctor, who advised that the emergency department should not be used to pain management and that, in his opinion, Appellant's chronic pain should be controlled and handled outpatient with Appellant's PCP. (Exhibit 16, page 15).

34. The screener further spoke with her supervisor and it was determined that mental health services were not appropriate as Appellant's issue was just his physical chronic pain and he should again be referred to the (Exhibit 16, page 15).

35. On the day set for the hearing in this matter, MAHS received a request to adjourn the hearing signed by Appellant in which he asked that the hearing be rescheduled because he had just been discharged from a nursing home and has not had time to prepare for the hearing. (Exhibit 20, page 8).

36. The undersigned Administrative Law Judge granted that request and the matter was rescheduled for . (Exhibit 20, page 8).

37. Appellant was again hospitalized on or about for his chronic pain and, while he was in the process of being discharged, he was screened by again. (Exhibit 20, pages 11-22).

38. Appellant reported severe pain and being anxious and overwhelmed about his services through possibly being terminated. (Exhibit 20, page 12).

39. The screener also noted that Appellant continued to refuse all referrals to other agencies and that he did not meet the criteria for an inpatient hospitalization for mental health reasons. (Exhibit 20, pages 13, 20-21).

40. Appellant was discharged from the hospital with additional pain medications. (Exhibit 20, page 21; Testimony of Appellant).

41. The telephone hearing in this matter was begun on , but could not be completed after Appellant was disconnected.

42. A continued hearing was then scheduled for .

43. On the hearing in this matter was continued and completed.

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.

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).

Regarding eligibility for mental health services through entities such as , the MPM states in part that:

1.6 BENEFICIARY ELIGIBILITY

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.

* * *

> Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when 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. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.
>
> Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.
>
> Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

MPM, April 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 3-4

Moreover, even if a beneficiary is generally eligible for mental health services through it, any specific service through [redacted] must meet the medical necessity criteria found in the MPM:

> **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. 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;
- 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;
  - 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, April 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 13-44

Here, Respondent initially terminated Appellant's services pursuant to the above policies after determining that Appellant was not engaged or interested in his therapy sessions; the psychiatric services he was interested in could be provided at the [redacted] where he has received psychiatric and medical services for years; and Appellant could also receive any necessary substance abuse services at the [redacted] as well. Moreover, while [redacted] later reauthorized services on a short-term basis, while Appellant was to be linked to other resources, in response to a local appeal and agreement with Appellant,

Appellant did not participate in any planning meeting, that short-term authorization expired, and determined that services should not be reauthorized.

Specifically, the notice of action at issue in this case provided that the clinical documentation did not establish medical necessity for services as Appellant does not have a severe and persistent mental illness and that Appellant's needs could be appropriately met through other community agencies.

In support of that decision, Respondent's representative testified regarding the history of Appellant's case and how Appellant's primary needs are medical in nature. She also testified that the mental health issues that Appellant does have are only comorbidities of his medical needs and not severe.

Respondent's Clinical Specialist further testified that Appellant has been on her caseload since but that he is only interested in pain medications and has declined individual therapy, including cognitive therapy and techniques for dealing with pain. She also testified that pain and mental health issues, such as depression, can go together, but that Appellant's mental health needs are not severe and he would be better served by having all of his needs met in one place.

In response, Appellant testified that was helping him, but now it is discarding him and that he cannot get his pain medications anywhere. In particular, Appellant noted that, while cognitive therapy is a joke, his therapist was helping by just talking to him and that is the only way he can get his necessary pain medications. He also testified that his PCP will not prescribe pain medications and that, while he has been going to the for years, it has never been good there. Appellant further testified that he has been in-and-out of the hospital for months, though he is not sure why, and that the pain medications he received on his most recent hospital visit have now run out.

Appellant bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for services.

Given the record in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed. It is undisputed in this case that Appellant has been diagnosed with mental health conditions, but he has also progressed through treatment over the years and his current mild or moderate psychiatric symptoms are not of sufficient severity or intensity to meet the criteria for services through the . Appellant himself is not even interested in therapy to address any current mental health issues, as opposed to getting medications for the pain, and he did not address any such symptoms beyond some vague, general comments during the hearing. Appellant's pain and the management of that pain are insufficient on their own to meet the criteria for mental health services through Respondent.

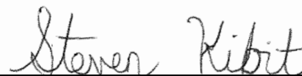
Moreover, even Appellant was eligible for services through services through it are not medically necessary as there exists a more appropriate and efficacious resource that can meet his needs, namely the . As testified to by Respondent's witnesses, given the relationship between Appellant's mental health needs and his physical pain, it is best for Appellant's pain and mental health to be managed together in one location. That is also particularly true in this case given past concerns raised about Appellant receiving pain medications through different avenues; his system for managing his medications on his own; and his substance abuse history. In response to claims that the can best meet all his needs, Appellant may have testified that he has had bad experiences there over the past years and he may have disagreed with the prescription of pain medications there in the past, but there is no evidence that the cannot meet Appellant's mental health needs and Appellant has instead simply refused all referrals.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that properly denied Appellant's request for reauthorization services.

IT IS THEREFORE ORDERED that:

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



Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed:

Date Mailed: _

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***** 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.