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:

[redacted]

Docket No. 15-010556 CMH
15-012751 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 requests for a hearing.

After due notice, a consolidated telephone hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] represented the Respondent [redacted] Contract Manager, testified as a witness for Respondent.

ISSUE

Did [redacted] properly deny Appellant's requests for reauthorization of individual therapy 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 schizoaffective disorder; major depressive affective disorder; and post-traumatic stress disorder. (Exhibit D, page 1).

2. Appellant was previously receiving individual therapy services through [redacted] (Testimony of [redacted]

3. In [redacted] Appellant therapist submitted a request on Appellant's behalf for reauthorization of the individual therapy services, with a start date of [redacted]. (Exhibit D, pages 1-13).

4. As part of the reauthorization form, the therapist was asked to "Briefly state why group treatment is clinically contraindicated". (Exhibit D, page 1).

5. Appellant's therapist left that portion of the form blank. (Exhibit D, page 1).

6. [redacted] reviewed that request and determined that it should be denied as individual therapy was not medically necessary and Appellant's needs could be met in group therapy. (Testimony of [redacted]

7. On [redacted] [redacted] sent Appellant written notice that her individual therapy services would terminate on [redacted] due to a lack of medical necessity. (Exhibit C, pages 1-2).

8. On [redacted], the Michigan Administrative Hearing Summary (MAHS) received a request for hearing filed by Appellant with respect to that decision. (Exhibit A, pages 1-2).

9. The appeal was docketed as Docket No. 15-010556 CMH.

10. On [redacted], MAHS sent out a notice of a hearing scheduled in Docket No. 15-010556 for [redacted]. (Exhibit B, page 1).

11. In [redacted] Appellant therapist submitted another request on Appellant's behalf for reauthorization of the individual therapy services, with a start date of [redacted]. (Exhibit E, pages 1-13).

12. In that reauthorization form, the therapist responded to the request to "Briefly state why group treatment is clinically contraindicated" by indicating that group therapy is not contraindicated, but that Appellant was not likely to attend due to her anxiety and paranoia. (Exhibit E, page 1).

13. [redacted] reviewed that request and determined that it should be denied as individual therapy was not medically necessary given that Appellant's needs could be met in group therapy; group therapy was not contraindicated; and Appellant has a case management agency who can assist her in attending group therapy. (Testimony of [redacted]

14. On [redacted], [redacted] sent Appellant written notice that her individual therapy services would terminate on [redacted] due to a lack of medical necessity. (Exhibit C, pages 1-2).

15. On [redacted], MAHS received a request for hearing filed by Appellant with respect to Respondent's [redacted] decision. (Exhibit A, page 4).

16. The second appeal was docketed as 15-012751 CMH.

17. Given the similar issues and evidence in Appellant's appeal, the two matters were consolidated at the request of the parties and a hearing was held on [redacted].

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.

Among the services that can be provided by Network 180 pursuant to that waiver are individual and group therapy services and, with respect to such services, the Medicaid Provider Manual (MPM) states:

> **3.12 INDIVIDUAL/GROUP THERAPY**
>
> Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.
>
> *MPM, July 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, page 18*

However, while individual therapy is a covered service, Medicaid beneficiaries are still only entitled to medically necessary services as the waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the applicable version of the MPM states:

> **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, July 1, 2015 version*
> *Mental Health/Substance Abuse Chapter, pages 13-14*

Here, both requests for reauthorization of individual therapy services were denied on the basis that they were not medically necessary. Specifically, Respondent's witness testified that Appellant's needs can met through group therapy and that Appellant's therapist never indicated that group treatment was contraindicated. Moreover, while Appellant's therapist did note concerns that Appellant would be unlikely to attend group sessions, Appellant also has a case management agency that can assist her in attending group therapy, including the assistance of peer specialists.

In response, Appellant testified that she does not want to go to group therapy because she is scared to go out and does not want to talk to a group. She also testified that she tried group therapy in the past and did not care for it; and that she needs individual therapy.

Appellant bears the burden of proving by a preponderance of the evidence that [redacted] erred by denying the requests for reauthorization of individual therapy and instead only approving group therapy.

Given the record in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that Respondent's decision must therefore be affirmed. While Appellant testified that she needs individual therapy, her testimony is unsupported by the written statements of her therapist and her preference for individual therapy over group therapy is insufficient to demonstrate a medical necessity for individual therapy. Moreover, even though Appellant's therapist did note concerns on whether Appellant would attend group therapy and Appellant testified that she did not care for such therapy, Appellant has demonstrated an ability to attend group therapy in the past and she currently has case management services that can assist her in attending.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly denied Appellant's requests for reauthorization of individual therapy services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

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

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

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.