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

IN THE MATTER OF

[redacted],

Appellant

Docket No. 15-015419 CMH
[redacted] [redacted]

_____/

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 commenced on [redacted]. The Appellant appeared and offered testimony on her own behalf. [redacted] appeared on behalf of the Respondent [redacted]). [redacted], Outpatient Supervisor and [redacted]., Medical Director appeared as witnesses for CMH.

ISSUE

Did CMH properly deny the Appellant Psychiatric 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 diagnosed with borderline personality disorder and a secondary diagnosis of a mood disorder. (Exhibit A, p 1; Testimony)

2. From approximately [redacted], the Appellant had been seeing a therapist at CMH. (Testimony)

3. On [redacted], the Appellant requested psychiatric services from CMH due to family stressors, mood swings and to manage her borderline personality disorder. At the time of the request, the Appellant was managing well on her current medication regime. (Exhibit A, pp 1, 4; Testimony)

4. On [redacted], CMH sent the Appellant an adequate action notice denying the Appellant's request for psychiatric services. (Exhibit A, pp 1, 5; Testimony)

5. Borderline Personality Disorder is best managed by psychotherapy and not by medication. (Exhibit A, p 1; Testimony)

6. On [redacted], the Michigan Administrative Hearing System received the Appellant's request for hearing.

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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. [redacted] CMH contracts with the Michigan Department of Community Health 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.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible. 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.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **2.5 MEDICAL NECESSITY CRITERIA**
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> 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.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.

MPM, Mental Health and Substance Abuse Section, July 1, 2014, pp 12-14

CMH's Outpatient Supervisor testified she received the request and reviewed the corresponding records and locus score and determined the Appellant did not meet the medical necessity criteria for psychiatric services. The Outpatient Supervisor indicated the Appellant was managing well on her current medication regime; was currently receiving therapy from a therapist; attending dialectical behavior therapy (DBT) and her locus score was on not reflective of a need for services.

CMH's Medical Director testified that Borderline Personality Disorders are best treated through therapy and not medication and that in his opinion, the request for psychiatric services was properly denied as there was no medical necessity for the requested services.

The Appellant testified she had only seen her therapist a few times and only talked with her therapist about her family and what why her family bothered her.

Based on the evidence presented, CMH properly denied the Appellant's request for psychiatric services. As indicated above, all services must be medically necessary, meaning those services are, "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." Here the Appellant did not require psychiatric services as she had attained a sufficient level of functioning in terms of community inclusion and participation, independence, recovery and productivity and her current treatment regimen included the primary forms of treatment for Borderline Personality Disorders.

The burden is on Appellant to prove by a preponderance of evidence that psychiatric services are still medically necessary. As indicated above, Appellant did not meet this burden.

DECISION AND ORDER

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

The CMH properly denied Appellant's request for psychiatric services.

IT IS THEREFORE ORDERED that:

The CMH's decision is AFFIRMED.

Corey Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Mailed: [redacted]

Date Mailed: [redacted]

CAA/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.