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:

MAHS Docket No. 15-017389 CMH

[redacted] [redacted] [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 a request for hearing filed on the minor Appellant's behalf.

After due notice, a telephone hearing was held on [redacted], Appellant's father, appeared and testified on Appellant's behalf. [redacted], Manager of Due Process, represented the Respondent [redacted], a Psychologist with [redacted]' Utilization Management, also testified as a witness for [redacted]

ISSUE

Did the [redacted] properly terminate Appellant's 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 Mood Disorder NOS; Asperger's Pervasive Development Disorder NOS or Rett Syndrome; and Attention Deficit Hyperactivity Disorder. (Exhibit A, page 42).

2. Appellant has been authorized for services through [redacted] and, in his most recent Individual Plan of Service (IPOS), for the time period of [redacted] through [redacted], his authorized services included mental health assessments by a non-physician; mental health service plan development by a non-physician; family training; Community Living Supports (CLS); respite care services; family therapy with Appellant

present; individual therapy; family psychotherapy with Appellant present; specialized wraparound services; medication reviews, occupational therapy. (Exhibit A, pages 17, 64-65).

3. On [redacted] Appellant's case manager/therapist met with Appellant for an individual session prior to Appellant's medication review. (Exhibit A, page 83).

4. On [redacted] Appellant also had a meeting with his wraparound services facilitator. (Exhibit A, pages 73-74).

5. Appellant never met with his wraparound services facilitator after [redacted], despite numerous attempts by the facilitator, on [redacted] and [redacted]; to schedule another meeting. (Exhibit A, pages 78-82).

6. On [redacted] Appellant's representative informed Appellant's case worker that Appellant's family was no longer interested in wraparound services. (Exhibit A, page 92; Testimony of Appellant's representative).

7. On [redacted] sent Appellant two written notices that his wraparound services were being terminated. (Exhibit A, pages 18-23).

8. Appellant never met with his case manager/therapist after [redacted]. (Testimony of Appellant's representative).

9. During a [redacted] phone call, the case manager/therapist indicated that she would be on a leave and that another case manager/therapist would be covering the case. (Exhibit A, page 87).

10. Upon her return from her leave, Appellant's case manager/therapist and Appellant's family scheduled a meeting/quarterly review for [redacted], though it took several phone calls to get Appellant's representative to schedule a date. (Exhibit A, pages 89-91).

11. However, on [redacted], Appellant's father cancelled the meeting/quarterly review. (Exhibit A, pages 47-65; 92).

12. Subsequently, on [redacted]; [redacted]; and [redacted]; Appellant's case manager/therapist again attempted to schedule a meeting without success. (Exhibit A, pages 93-96).

13. Appellant's occupational therapist was likewise unable to schedule a meeting with Appellant, despite making attempts to do so on [redacted]; [redacted] Exhibit A, pages 97-104).

14. On [redacted] sent Appellant written notices that his remaining family support services; psychiatric services, respite care services; occupational therapy, and consultative services were being terminated for noncompliance with treatment. (Exhibit A, pages 26-34).

15. In her subsequent review, [redacted]' psychologist/witness noted:

> *Advance notice for Wraparound sent [redacted] to terminate Wrap services per family request/ refusal of that service. Advance notice for CM, psychiatric and respite services sent [redacted] d/t noncompliance (see above). While client presents w/ Hx, Sx and behaviors which are certainly consistent w/ SED, he has not been meeting medical necessity for ongoing [redacted] services d/t Tx noncompliance. Per chart review, It would appear that pretty much the only services the family has been utilizing have been med clinic app'ts (none since last J[redacted], as CM have app'ts not been kept (and also no units billed against respite authorization, either). Client has Medicaid (they need to choose an MHP) and may utilize med services via a MHP provider, if this is what they choose to follow up with, as psychiatric services are a covered benefit and they have not been utilizing other services despite [Appellant's] Hx.*
>
> *Exhibit A, page 38*

16. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit 1, page 1).

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.

[redacted] 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 [redacted], 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, July 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 13-14

Here, [redacted] terminated Appellant's services after finding that he had been failing to utilize them and noncompliant with his treatment plan. In particular, its witness noted that Appellant had repeatedly failed to meet with his case manager/therapist; wraparound facilitator, or occupational therapist over the course of several months despite repeated attempts to schedule meetings and treatment. [redacted]' witness also noted that Appellant was, at most, using medication review services, but that such services could also be provided through his Medicaid Health Plan (MHP). She further testified that Appellant needs compliance with treatment in order to show medical necessity as a beneficiary has to participate in order to get benefits from treatment.

In response, Appellant's representative acknowledged that Appellant and his family have missed a number of appointments due to extenuating circumstances, which included job changes for Appellant's parents, surgeries for Appellant's father, and a leave by Appellant's therapist. However, he also testified that Appellant still needs services as they have had difficulties since Appellant has been weaned off medications. Appellant's representative further testified that they are not interested in many of the services that were previously approved, but that they still want and need the medication reviews, psychiatric services and respite care. He also testified that he thought they

were done with occupational therapy and does not know why the occupational therapist was trying to contact them, but that they would still be interested in it if there was more to do.

Appellant bears the burden of proving by a preponderance of the evidence that [redacted] erred in terminating his services.

Based on the evidence presented in this case, Appellant has failed to meet that burden of proof and the Respondent's decision must be affirmed. [redacted] provided credible evidence that its termination of Appellant's services was proper given that Appellant failed to utilize the authorized services over an extended period of time. While Appellant's representative identified reasons for the repeated failure to meet with his case manager/therapist; wraparound facilitator, or occupational therapist, his reasons are insufficient given the extended length of time they failed to meet and, regardless, that does not mean that it was improper for [redacted] to terminate the services. As indicated above, to be medically necessary, services must be: intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder, expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or be designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve goals of community inclusion and participation, independence, recovery, or productivity. If Appellant was not using the services provided, then the services were not medically necessary because they were not treating his condition, arresting the progression of his condition, or helping his to achieve independence and community inclusion. Accordingly, the Respondent's decision must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the [redacted] properly terminated Appellant's 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]

[redacted]
Docket No. 15-017389 CMH
Decision and Order

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.