RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

[redacted]

MAHS Docket No.: 16-001443

[redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. Petitioner appeared and testified on her own behalf. [redacted], attorney, represented the Respondent [redacted]. [redacted] Clinical Grants and Training Specialist, testified as a witness for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for case management 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. Petitioner is a [redacted]-year-old Medicaid beneficiary who has been diagnosed with bipolar disorder and posttraumatic stress disorder (PTSD). (Exhibit A, page 3).

2. In [redacted], Petitioner was approved for Medicaid-covered mental health services through [redacted] and [redacted]), a Community Mental Health Services Program (CMHSP) affiliated with the Respondent Prepaid Inpatient Health Plan (PIHP). (Exhibit A, page 1; Testimony of Respondent's witness).

3. As part of her services at the time, Petitioner received psychiatric services

and case management services at [redacted]), a contracted service provider. (Exhibit A, pages 1-2; Testimony of Respondent's witness).

4. By [redacted] it was determined that Petitioner was stable and had met her treatment goals, and she was therefore scheduled to be discharged on [redacted]. (Exhibit A, pages 1-2).

5. However, Petitioner moved out-of-state prior to the scheduled discharge in order to receive treatment for breast cancer and her last date of service was [redacted]. (Exhibit A, page 2).

6. Following her return to [redacted]n, Petitioner requested psychiatric services through [redacted] on [redacted]. (Exhibit A, page 2; Exhibit C, pages 1-7).

7. Petitioner initially requested psychiatric services through [redacted] but, after being informed that she could only receive psychiatric services at [redacted] if she also received case management services there, Petitioner later requested both psychiatric services and case management services at [redacted] (Exhibit A, page 2; Exhibit C, page 6).

8. In response, [redacted] authorized psychiatric services, but not case management services, and Petitioner could not receive the authorized psychiatric services at [redacted]. (Exhibit A, page 2; Exhibit C, page 6).

9. Petitioner subsequently attended a medication review and a psychiatric evaluation as part of her psychiatric services, but she also made repeated requests asking for case management services. (Exhibit A, pages 2-5; Exhibit B, pages 1-7).

10. On [redacted], Petitioner's request/grievance for case management was received by [redacted]' Customer Services Department. (Exhibit A, page 1; Exhibit E, pages 4-5).

11. [redacted] then reviewed the request and determined that it should be denied. (Exhibit A, pages 1-6; Exhibit E, pages 4-5)

12. With respect to the reason for the denial, the assessor at [redacted] found that Petitioner did not meet the criteria for case management as Petitioner did not identify any coordination needs with any medical providers; she has historically been able to schedule and attend dental appointments, with her primary care physician able to make any future referrals; case managers had been unable to assist Petitioner in obtaining independent housing for years in the past and Petitioner's capacity to benefit from it in that area was minimal; Petitioner was able to obtain and

maintain employment in the past; and Petitioner had no identified risk factors. (Exhibit A, pages 5-6).

13. On or about [redacted], Petitioner filed an appeal of that denial with [redacted] (Exhibit 1, page 2).

14. On [redacted] conducted a review of Petitioner's appeal. (Exhibit E, pages 1-5).

15. On [redacted] sent Petitioner written notice that the decision to deny her request for case management services had been upheld as Petitioner did not meet the medical necessity requirement for such services. (Exhibit 1, pages 2-3).

16. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that determination. (Exhibit 1, pages 1-3).

17. Following receipt of the request for hearing, Respondent reviewed the decision and found that it should be upheld. (Exhibit F, pages 1-7).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…
>
> *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) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner is requesting case management services through Respondent and its affiliated CMHSP KCMHSAS.

With respect to such services, the Medicaid Provider Manual (MPM) provides in part:

> **SECTION 13 – TARGETED CASE MANAGEMENT**
>
> Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental

services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary’s record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.

- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.

- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.

- Identifying and addressing gaps in service provision.

- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.

- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.

- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.

- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.

- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.

- Assisting beneficiaries with crisis planning.

- Identifying the process for after-hours contact.

MPM, October 1, 2015 version
Mental Health/Substance Abuse, pages 82-83

However, while case management is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program 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 MPM also 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, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 12-14

Here, while Respondent approved and authorized the psychiatric services requested by Petitioner, it denied Petitioner's request for case management services on the basis that such services were not medically necessary.

In support of that decision, Respondent's witness testified that Petitioner does not need case management and that it appears she is only seeking it in order to receive psychiatric services at [redacted], which only provides psychiatric services if a client is also receiving case management services there. She also noted that some of the benefits Petitioner identified as coming from case management, such as therapy and transportation, are not actually functions of the service and that Petitioner does not need what case management actually provides. She further testified that Petitioner was in the process of being discharge from services back in [redacted] because she was stable and, to the extent Petitioner currently needs some assistance with things like housing or SSI, there are other available resources and case management services are not warranted.

In response, Petitioner testified that, with her PTSD, it is impossible for her to live a normal day-to-day life and very hard for her to go out into the community. She also testified that her case managers in the past have helped her with SSI and finding employment; talking to her about her day-to-day life and providing therapy; and teaching her skills. Petitioner further testified that the psychiatrists she has seen since her return to [redacted] have not helped her at all.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her request for case management services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed. Case management is meant to assist beneficiaries in obtaining services/supports, including but not limited to health and dental services, financial assistance, housing, employment, education and social services, through assistance such as assessments, planning, linkage, advocacy, coordination and monitoring, but Petitioner does not appear to need or even want such services at this time. The mere fact that case management helped Petitioner in the past does not mean that it is currently necessary and Petitioner does not identify any current need for assistance with obtaining services or supports. Instead, as noted by Respondent, Petitioner's reasons for requesting case management services are for things like transportation and having someone to talk to, which is not the purpose of case management. Similarly, Petitioner's dissatisfaction with her current psychiatrists also does not warrant case management services, even if authorizing the services would allow her to see the specific provider she wants to. Accordingly, given the lack of medical necessity, Respondent's denial must be affirmed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/db

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

[redacted]