



RICK SNYDER  
GOVERNOR

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

SHELLY EDGERTON  
DIRECTOR



Date Mailed: January 11, 2017  
MAHS Docket No.: 16-016175  
Agency No.: [REDACTED]  
Petitioner: [REDACTED]

**ADMINISTRATIVE LAW JUDGE:** Landis Lain

**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 January 4, 2017. Petitioner's mother [REDACTED] appeared on behalf of the Petitioner. [REDACTED], Manager of Due Process and [REDACTED], Utilization Management Coordinator represented the Region 10 Prepaid Health Plan (Respondent).

Respondent's Exhibit A pages 1-28 were admitted as evidence.

**ISSUE**

Did the Respondent properly deny Petitioner 16 hours of Respite Care (RC) per month?

**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 Medicaid beneficiary, (Date of birth [REDACTED]).
2. Petitioner is currently receiving the Medicaid Specialty Mental Health Services and Supports of Targeted Case Management, Individual Therapy, Family Training, Family Therapy and Respite Care Services.
3. On October 21, 2016, a formal request was made to the GHS Utilization Management Department for the authorization of Respite Care in the amount of 50 hours per month, an increase from the 33 hours of Respite Care previously authorized.

4. Upon review of the documentation it was determined that the beneficiary met the medical necessity for 34 hours of Respite Care per month.
5. On October 21, 2106, a Limited Denial Notice was sent to Petitioner's parent with appeal rights and instructions, indicating that Petitioner is approved for 34 hours of Respite Care per month and denied 16 hours of Respite Care.
6. On November 2, 2016, the Michigan Administrative Hearing System received a Request for Hearing to contest the denial of additional Respite Care hours.
7. On November 3, 2016, the parent field a local appeal with the PIHP and as a result of the appeal, the Respite Care authorization was changed to 38 hours per month.

### **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).

The Region 10 PIHP is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Michigan Mental Health Code explicitly states:

### **330.1712 Individualized written plan of services.**

Sec. 712.

(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The

individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

**History:** 1974, Act 258, Eff. Aug. 6, 1975 -- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

The Michigan Mental Health Code, Section 330.1100a, defines developmentally disabled as:

(21) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

- (i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
- (ii) Is manifested before the individual is 22 years old.
- (iii) Is likely to continue indefinitely.
- (iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

- (A) Self-care.
- (B) Receptive and expressive language.
- (C) Learning.
- (D) Mobility.
- (E) Self-direction.
- (F) Capacity for independent living.
- (G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that

are of lifelong or extended duration and are individually planned and coordinated.

Medicaid beneficiaries are 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*.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

## **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; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- 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; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- 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;
  - 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.

***Medicaid Provider Manual  
Behavioral Health and Intellectual and  
Developmental Disability Supports and Services Chapter  
January 1, 2017, pp 12-14***

### **17.3.I. RESPITE CARE SERVICES**

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

Respite care may not be provided by:

- **parent of a minor beneficiary receiving the service**
- spouse of the beneficiary served
- **beneficiary's guardian**
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

***Medicaid Provider Manual  
Behavioral Health and Intellectual and  
Developmental Disability Supports and Services  
January 1, 2017, pages 139-140***

Respite Care is based strictly upon the needs of the beneficiary. After careful consideration the Region 10 has determined that Petitioner has the medical necessity to receive 38 hours per month in Respite Care. 38 hours in Respite Care when combined with other services provided to Petitioner are sufficient to be the scope and duration of medically necessary services for Petitioner. The Region 10 did consider all of Petitioner's concerns and medical needs when making the determination.

Region 10 has established by the necessary competent, substantial and material evidence on the record that it was acting in compliance with Department and Medicaid policy when it reconsidered Petitioner's request for additional Respite Care hours and increased the Respite Care hours to 38 hours per month. The Respondent's actions must be upheld.



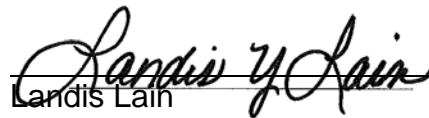
**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent's decision to grant Petitioner 38 hours per month in Respite Care is sufficient and appropriate under the circumstances.

**IT IS THEREFORE ORDERED** that

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

LL/sb



Landis Lain

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

**DHHS -Dept Contact**

[REDACTED]

**Petitioner**

[REDACTED]

**DHHS Department Rep.**

[REDACTED]