RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: January 10, 2017
MAHS Docket No.: 16-016182
Agency No.: [redacted]
Petitioner: [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 Petitioner's request for hearing.

After due notice, a telephone hearing was held on January 4, 2017. Petitioner appeared and testified on his own behalf. [redacted], Petitioner's sister, also testified as a witness for Petitioner. [redacted] Fair Hearing Officer, appeared and testified on behalf of Respondent [redacted]. [redacted] Manager, and [redacted], also testified as witnesses for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for continuation of 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. Petitioner is a fifty-three-year-old Medicaid beneficiary who is enrolled in [redacted], a Medicaid Health Plan (MHP). (Exhibit A, page 3; Testimony of Petitioner).

2. Through Respondent, Petitioner had also been seeing a psychiatrist once every three months. (Testimony of Petitioner; Testimony of [redacted]).

3. Petitioner was diagnosed with paranoid schizophrenia in the year 2011, but has been stable for over four years. (Exhibit A, page 4; Testimony of Petitioner; Testimony of [redacted].

4. On October 25, 2016, Respondent received a request for continuation of psychiatric services submitted on Petitioner's behalf. (Exhibit A, page 3).

5. That same day, Respondent sent Petitioner written notice that his request to see a psychiatrist at Respondent's Physician's Services Unit had been denied. (Exhibit A, pages 5-7).

6. Regarding the reason for the denial, the notice also stated in part:

> According to documentation, you have been doing very well on your medications without any medication changes. Your Primary Care Physician can prescribe the medication. Please schedule and [sic] appointment to see your Primary Care Physician for medication management.
>
> * * *
>
> You do not meet the clinical eligibility criteria for services. You do not meet Medicaid eligibility for services as a person with a serious mental illness, a person with a developmentally disability, or a child with a serious emotional disorder or a person with a substance abuse disorder.

Exhibit A, page 5

7. On November 4, 2016, Petitioner completed a Grievance/Appeal & Dispute Resolution Form for a Local Appeal with Respondent. (Exhibit A, page 8).

8. On November 9, 2016, the Michigan Administrative Hearing System received a request for hearing filed by Petitioner with respect to the denial of his request. (Exhibit A, pages 12-13).

9. On December 15, 2016, Respondent sent Petitioner written notice that, following a secondary review conducted as part of the Local Appeal, it was upholding the original denial. (Exhibit A, pages 10-11).

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.

Eligibility for services through Respondent is set by Department policy, as outlined in the Medicaid Provider Manual (MPM). Specifically, the applicable version of the MPM states in the pertinent 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.
>
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emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is 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. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or

supports.	prevent relapse. ▪ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

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, October 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
pages 3-4
(Emphasis added by ALJ)

The State of Michigan's Mental Health Code defines mental illness and serious emotional disturbance as follows:

> 2. "Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or

community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

a. A substance abuse disorder.
b. A developmental disorder.
c. "V" codes in the diagnostic and statistical manual of mental disorders.

3. "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:

a. A substance abuse disorder.
b. A developmental disorder.
c. A "V" code in the diagnostic and statistical manual of mental disorders.

MCL 330.1100d

Here, Respondent denied Petitioner's request for services pursuant to the above policy and statute. In particular, both its notices of denial and the testimony of its witnesses during the hearing provided that, based on the information submitted, Petitioner no longer met the above criteria for a serious mental illness and, while he may have mild to moderate mental health needs, those needs can be met through his MHP. [redacted] also noted that Petitioner has been stable for over four years and he has no functional impairments.

In response, Petitioner testified that he needs to see a psychiatrist on a regular basis, once every three months, due to his schizophrenia and that his diagnosis, which was only made in 2011, is still new. Petitioner further testified that his current services have

been keeping him stable, but that he does not know what will happen if he has to go through his MHP and primary care physician, who is not a psychiatrist.

Petitioner's sister testified that, while Petitioner has been doing well for the past several years, he still has some anxiety and hears some voices. She also testified that she is worried that a change in services could be dangerous for Petitioner and send him into a downward spiral. She further testified that she worked for Respondent in the past and knows they can tweak things to get Petitioner services.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for services. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information it had at the time it made that decision.

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed. It is undisputed in this case that Appellant has been diagnosed with a mental, behavioral, or emotional disorder that has existed for over a year, but the evidence also reflects that Petitioner has been stable for years and that his disorder no longer causes any functional impairment that substantially interferes with or limits one or more major life activities. Petitioner is understandably concerned about what may happen in the future, but he and his witness do not dispute Respondent's witnesses' testimony and they failed to demonstrate that Petitioner meet the criteria for having a serious mental illness.

Additionally, even if Petitioner did meet the criteria for a serious mental illness, he has failed to show that his needs exceed his MHP benefits. The MPM provides that MHPs are generally responsible for outpatient mental health services where a beneficiary was formerly significantly or seriously mentally ill at some point in the past, but the signs and symptoms of the former serious disorder have substantially moderated or remitted; prominent functional disabilities or impairments related to the condition have largely subsided; and the beneficiary currently needs ongoing routine medication management without further specialized services and supports. That is the case here, where Petitioner has been stable for years and his medications remain unchanged; and where he only sees a psychiatrist once every three months and his MHP can provide up to 20 visits per year.

If Petitioner exhausts his services through the MHP or its services are insufficient, then he can always re-request services through Respondent in the future. With respect to the decision at issue in this case however, Respondent's decision to deny Petitioner's request for services 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 continuation of psychiatric services.

IT IS, THEREFORE, ORDERED that:

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

SK/tm

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

Petitioner

[redacted]

[redacted]

[redacted]