[redacted]
, MI [redacted]

Date Mailed: June 30, 2020
MOAHR Docket No.: 20-002851
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on May 28, 2020. [redacted], Petitioner's parents, appeared and testified on Petitioner's behalf. [redacted], Supports Coordinator, appeared as a witness for Petitioner. Stacy Coleman-Ax, Chief Compliance Officer, appeared and testified on behalf of Respondent, Macomb County Community Mental Health (CMH).

ISSUE

Did the Respondent properly deny Petitioner the ability to submit a request for an iPad?

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, born [redacted], diagnosed with Autism disorder as well as expressive and receptive language disorder. (Exhibit 2, p 7; Exhibit A, p 12; Testimony)

2. On March 25, 2020, Administrative Law Judge Colleen Lack issued a Decision and Order in which she upheld the CMH's denial of Petitioner's prior request for an iPad. (Exhibit A, pp 12-27; Testimony)

3. In early April 2020, Petitioner's Supports Coordinator attempted to submit a new request for an iPad after working with Petitioner's parents to update Petitioner's IPOS to address issues raised in ALJ Lack's Decision. (Exhibits 1, 2; Testimony)

4. On April 4, 2020, CMH notified Petitioner that it would not accept Petitioner's new request for an iPad because of ALJ Lack's recent decision. CMH directed Petitioner to the appeal rights contained in that Decision and Order. (Exhibit A, p 2; Testimony)

5. On May 4, 2020, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 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 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 Health and Human Services (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

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 CMH 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 applicable sections of the Medicaid Provider Manual (MPM) provide:

> **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, 2020, pp 12-14

CMH's witness testified that CMH refused to accept the new request for an iPad because ALJ Lack considered all possible options for coverage of an iPad through Medicaid and determined that an iPad was not covered.

Petitioner's witnesses testified that there were errors in ALJ Lack's Decision and Order and further that the decision did not consider all possible avenues for covering an iPad through Medicaid.

Based on the evidence presented, Petitioner has proven, by a preponderance of the evidence, that CMH erred in denying Petitioner the ability to even submit a new request for an iPad. As indicated above, policy requires that determinations regarding medical necessity must be based on information provided by the beneficiary, clinical information, and person centered planning and those determinations must be made by appropriately trained professionals and documented in the individual plan of service. (*See MPM, Section 2.5.B above*). Nowhere in policy does it indicate that decisions regarding medical necessity should be made based on prior decisions made by ALJ's. As such, the fact that ALJ Lack recently issued a Decision and Order upholding CMH's denial of a prior request for an iPad does not prevent Petitioner from submitting a new request. While the CMH is free to deny a new request for an iPad based on the reasoning in ALJ Lack's Decision and Order, the CMH cannot deny Petitioner the right to even submit such a request. And, depending on what changes Petitioner made to his IPOS prior to submitting the new request for an iPad, it is possible that there may be new issues or circumstances that were not considered in ALJ Lack's Decision and, if that is the case, a further review by an ALJ would be appropriate. Of course, if the circumstances have not changed, and ALJ Lack did in fact consider all options for obtaining an iPad through Medicaid, then further analysis would not be required in the subsequent appeal and the issue would be settled at the administrative level under the legal doctrine of *res judicata*. (See, generally, *The Mable Cleary Trust v The Edward-Marlah Muzyl Trust,* 262 Mich App 485 (2004)). However, whether *res judicata* applies is a determination for the court to make; not a determination to be made by the CMH. As such, the CMH's decision was improper and should be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly denied Petitioner the ability to submit a new request for an iPad.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Within 10 days of this Decision and Order, CMH must certify that it will accept and consider Petitioner's most recent request for an iPad and issue an appropriate benefit determination notice after considering Petitioner's request consistent with the medical necessity criteria found in policy.

RM/ sb

Robert J. Meade
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
48913

Authorized Hearing Rep.

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DHHS-Location Contact

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Macomb County CMHSP
22550 Hall Road
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