[redacted]
[redacted]
[redacted], MI [redacted]

Date Mailed: December 16, 2021
MOAHR Docket No.: 21-005168
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 a hearing.

After due notice, a telephone hearing was held on December 14, 2021. [redacted], Petitioner's parents and legal guardians, appeared and testified on Petitioner's behalf, with Petitioner also present during the hearing. Bryan Krogman, Deputy Director for Administration, appeared and testified on behalf of the Respondent Community Mental Health of Central Michigan. Angela Zywicki, Utilization Manager, also testified as a witness for Respondent.

During the hearing, Petitioner's Request for Hearing was admitted into the record as Exhibit #1, pages 1-16. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-16.

ISSUE

Did Respondent properly reduce Petitioner's mileage authorization?

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] ([redacted]) year-old Medicaid beneficiary who has been diagnosed with PANDAS Syndrome; MRSA; Sleep Apnea; and Down Syndrome. (Exhibit A, pages 4-5).

2. Petitioner has also been approved for services through Respondent pursuant to the Habilitation Supports Waiver (HSW). (Exhibit A, page 6; Testimony of Petitioner's mother).

3. As part of his services through Respondent, Petitioner has been approved for both Community Living Supports (CLS) and mileage reimbursement in support of those CLS. (Exhibit A, pages 7).

4. On August 13, 2021, a Person-Centered Plan Meeting was held with respect to the upcoming plan year. (Exhibit A, page 4).

5. During that meeting, Petitioner's guardians requested reauthorization of Petitioner's mileage reimbursement in the same amount as before. (Testimony of Petitioner's Mother; Testimony of Utilization Manager).

6. However, Respondent subsequently determined that only a reduced amount of 600 miles per month should be approved, and only put that amount in the approved plan later sent to Petitioner. (Testimony of Respondent's representative).

7. The plan sent to Petitioner identified the reduced amount approved, but it did not give any reason why Petitioner's request was denied. (Exhibit A, pages 4-16).

8. It did say that Petitioner could request an Internal Appeal if he disagreed with the PCP. (Exhibit A, page 15).

9. On September 28, 2021, Petitioner filed an Internal Appeal with respect to the reduced mileage authorization. (Exhibit #1, page 2).

10. On October 18, 2021, Respondent sent a Notice of Internal Appeal Denial stating that the Internal Appeal had been denied. (Exhibit #1, page 2).

11. With respect to the reason for the decision, the notice stated:

> An independent reviewer agreed with the decision to deny the request for authorization for 950 miles per month. Based on chart review, the highest mileage claimed in a year span (PCP year) was 7,964, which breaks down to 664 miles/month, or 154 miles/week. The amount of 900 miles/month has never been utilized in the past. Given the distance from [Petitioner's] home to locations he would like to go, current authorizations of 600 miles per month is sufficient. If there is a need for more mileage above the 600/month, accommodations can be made through addendums.

Exhibit #1, page 2

12. On November 1, 2021, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter with respect to Petitioner's mileage authorization. (Exhibit #1, pages 1-6).

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 has been receiving mileage reimbursement through Respondent in support of his CLS services.

All services through Respondent must be medically necessary and, with respect to the medical necessity, the Medicaid Provider Manual (MPM) governing the services in this case provides:

> **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, July 1, 2021 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 14-15

Here, as discussed above, while Petitioner requested the reauthorization of his previous mileage authorization as part of his most recent Person-Centered Plan, Respondent denied that request and instead reduced Petitioner's approved services.

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

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has met his burden of proof and that Respondent's decision must therefore be reversed.

Respondent denied Petitioner's reauthorization request and reduced his services, but it did not send Petitioner timely and adequate notice of an adverse benefit determination as required by 42 CFR 438.404. Rather than sending such a notice, Respondent just entered the reduced amount in the Person-Centered Plan and, while that plan informed Petitioner of the action and his right to appeal it, it failed to explain the reasons for the negative action as expressly required by 42 CFR 438.4040(b)(2).

Moreover, while Respondent's denial of Petitioner's Internal Appeal subsequently identified reasons for that decision, Petitioner has demonstrated that those reasons are improper. For example, the Notice of Appeal Denial notes that Petitioner has not utilized his approved amount of mileage in the past, but the Person-Centered Plan provides that staffing shortages, including shortages due to the ongoing COVID-19 pandemic, rather than the lack of any medical necessity, have limited his use of those services and that Petitioner has now switched to a provider agency. Similarly, while the Notice of Appeal Denial states that the reduced amount is sufficient to meet Petitioner's needs given the distance from Petitioner's home to the locations he would like to go, that finding fails to take into account the staffing shortages and Petitioner's recent move to a new location.

It is not clear that Petitioner is entitled to all the mileage he seeks, with Respondent correctly noting that Petitioner's preference for certain locations or activities does not necessarily equate to medical necessity, but based on the record before him, the undersigned Administrative Law Judge finds that Respondent erred in reducing Petitioner's mileage authorization and that it must initiate a reassessment of that approval.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly reduced Petitioner's mileage authorization.

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED,** and it must initiate a reassessment of Petitioner mileage authorization.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge

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

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