[redacted]

Date Mailed: March 9, 2023
MOAHR Docket No.: 22-004094, 22-004095, 22-004804, 22-004805
Agency No.: [redacted]
Petitioners: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

The above four matters are before the undersigned Administrative Law Judge (ALJ) upon Petitioners' requests for hearing and pursuant to MCL 400.9; 42 CFR 431.200 *et seq.*; and 42 CFR 438.400 *et seq*.

On September 7, 2022, Petitioners [redacted] and [redacted] (Petitioners) each filed requests for hearing through their guardian against Respondent Northern Lakes Community Mental Health Authority (NLCMHA or Respondent), with the two matters docketed separately: 22-004094 CMH ([redacted] v NLCMHA) and 22-004095 CMH [redacted] v NLCMHA). By agreement of the parties, the cases were subsequently consolidated for purposes of hearing.[1]

On October 11, 2022, Petitioners each filed new requests for hearing through their guardian against NLCMHA, with the two matters docketed separately: 22-004804 CMH [redacted] v NLCMHA) and 22-004805 CMH [redacted] v NLCMHA). At the request of Petitioners and by order of the ALJ, those two new matters were subsequently consolidated with the two consolidated cases filed earlier.[2]

As part of the proceedings in the consolidated matters, the parties and ALJ agreed that the parties would have an opportunity to file dispositive motions prior to an administrative hearing being scheduled, and both parties timely filed motions for summary disposition and responses in opposition to motions for summary disposition.

On February 8, 2023, the undersigned ALJ issued a Decision and Order on Motions for Summary Disposition in which he ruled in part that (1) Petitioners' Motion for Summary Disposition was denied; (2) NLCMHA's Motion for Summary Disposition was granted in

[1] Petitioners also filed requests for hearing against the Area Agency on Aging of Northwest Michigan (AAANM) at the same time and, while those matters were consolidated with the claims against NLCMHA as well, the claims against AAANM were subsequently dismissed.
[2] Petitioners again filed new requests for hearing against the AAANM at the same time, and those matters were also subsequently consolidated with the other cases before being dismissed.

part and denied in part; and (3) the matters would proceed to hearing with respect to the alleged improper denials of enhanced pharmacy items and skilled therapies.

On February 23, 2023, a telephone hearing was held as scheduled. Attorney Craig W. Elhart represented Petitioners. Attorney P. David Vinocur represented Respondent.

During the hearing, the following witnesses testified:

Petitioners' Witness:

[redacted] Petitioners' Guardian

Respondent's Witness:

Margaret Henning, Case Manager

The following exhibits were also entered into the record:

Petitioners' Exhibits:

Exhibit A: Documents attached to First Request for Hearing

Exhibit B: Documents attached to Second Request for Hearing

Exhibit C: Documents attached to Response to Motions for Summary Disposition

Respondent's Exhibits:

Exhibit #1: Decision and Order dated January 31, 2022

Exhibit #2: Notices of Adverse Benefit Determination

ISSUES

Did Respondent properly deny Petitioners' requests for Enhanced Pharmacy Items and Skilled Therapies?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioners are Medicaid beneficiaries who are enrolled in Medicaid Fee for Service. (Testimony of Petitioners' guardian; Testimony of Case Manager).

2. Petitioners also have private insurance through Priority Health. (Testimony of Petitioners' guardian; Testimony of Case Manager).

3. Petitioners are further authorized for services through Respondent. (Testimony of Petitioners' guardian; Testimony of Case Manager).

4. As part of their services through Respondent, Petitioners are approved for Case Management, Family Therapy, and Enhanced Pharmacy. (Testimony of Case Manager).

5. In a Decision and Order dated January 31, 2022, Administrative Law Judge Robert J. Meade also ordered:

> [Respondent] will cover all of Petitioners' medically necessary needs for Speech Therapy, Occupational Therapy, Physical Therapy . . .
>
> *Exhibit #1, page 17*

6. Petitioners have repeatedly requested additional Enhanced Pharmacy items and skilled therapies, including occupational therapy (OT), physical therapy (PT), and speech and language therapy (SLT). (Testimony of Petitioner's guardian).

7. Respondent have sent Adverse Benefit Determinations denying some of those requests while verbally denying or refusing to process others. (Exhibit #2, pages 1-7; Testimony of Petitioner's guardian).

8. In each instance, the denial or refusal to process was based on Petitioners allegedly failing to show that the requested items or services had already been denied by both Petitioners' private insurance and their Medicaid Fee for Service. (Testimony of Case Manager).

9. Petitioners requested an Internal Conference regarding the denials, but Respondent denied any request to hold an Internal Conference on those issues. (Exhibit A, page 9; Testimony of Petitioners' guardian).

10. Petitioners then filed the requests for hearing in these matters. (Testimony of Petitioners' guardian).

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)) (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, Petitioners have been requesting Enhanced Pharmacy Items and Skilled Therapies through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

3.19 OCCUPATIONAL THERAPY

Evaluation	Therapy
Physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher,

	registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

* * *

3.22 PHYSICAL THERAPY

Evaluation	Therapy
Physician/licensed physician's assistant-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a

	physician/licensed physician's assistant and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.

3.23 SPEECH, HEARING, AND LANGUAGE

Evaluation	Therapy
Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.	Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical

	or functional status were the therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

17.3.C. ENHANCED PHARMACY

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. *There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.*

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
- A history of aspiration pneumonia, or
- Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

Page 139
(Italics added for emphasis)

Moreover, while not at issue in this case, Petitioners have also been approved for case management through Respondent:

> **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.* For children and youth, a family driven, youth guided planning process should be utilized. 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.
>
> * * *
>
> **13.3 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.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	*The beneficiary's record must contain sufficient information to document the provision of case*

	management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.

Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter
Page 139
(Italics added for emphasis)

Additionally, any service authorized through Respondent must be medically necessary. Regarding the required medical necessity, the MPM also 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, 2022 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 14-16*

Here, as discussed above, Petitioners' repeated requests for skilled therapies and additional Enhanced Pharmacy items have been denied on the basis that Petitioners failed to show that the requested items or services had already been denied by both Petitioners' private insurance and their Medicaid Fee for Service.

In appealing those denials, Petitioners bear the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decisions in light of the information it had at the time it made any decision.

Given the record in this case, Petitioners have met that their burden of proving that Respondent erred and, consequently, Respondent's decisions must therefore be reversed.

Respondent is correct that denials from other payors need to be provided prior to it approving or paying for any services, with the MPM both generally providing that services are not medically necessary where there exists other services or supports that otherwise satisfy the standards for medically necessary services and specifically stating that Enhanced Pharmacy items require documented evidence that an item is not available through Medicaid or other insurances.

Moreover, it is undisputed in this case that Petitioners have not provided denials from all other potential payors as required by policy and repeatedly requested by Respondent, with Petitioners at most providing a denial from Priority Health regarding Enhanced Pharmacy items.

Accordingly, without that required documentation, Petitioners' request cannot be approved.

However, while the requests could not be approved, the record still demonstrates that the denials in this case were issued in error as Respondent issued them without providing the approved targeted case management for Petitioners.

Petitioners' guardian credibly testified that, despite multiple attempts, she has been unable to get the required denials from Medicaid Fee for Service for Enhanced

Pharmacy items or arrange a provider for the skilled therapies, and that she has requested assistance from Respondent in coordinating with other payors.

Moreover, the MPM expressly provides that targeted case management includes assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed services; the service's core requirements include "[c]oordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary; and the beneficiary's record must contain sufficient information to document the provision of case management.

Here, beyond a brief description from Respondent's witness regarding initial referrals for skilled therapies, Petitioners' guardian's testimony that she sought assistance from the case manager in coordinating Petitioners' services and that Respondent failed to provide any assistance is uncontradicted.

For example, while Petitioners' guardian credibly described her unsuccessful attempts to obtain denials from Medicaid Fee for Service with respect to Enhanced Pharmacy items, as well as her request for assistance from Respondent in obtaining such denials, as she claims Respondent provided in the past, Respondent's witness simply testified that it needs denials from other payors to even process requests and its representative put the responsibility for providing the denials solely on Petitioners' guardian. Respondent also failed to provide any testimony or documentation regarding case management or assistance provided to Petitioners.

Targeted Case Management was approved in these cases, but Respondent failed to provide any in response to Petitioners' guardian's request for assistance in coordinating services and, instead, simply denied services. By doing so, it erred; its decisions must be reversed; and it must reassess Petitioners' requests in light of the approved case management services.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent erred in denying Petitioners' requests for additional Enhanced Pharmacy items and skilled therapies.

IT IS THEREFORE ORDERED that:

- Respondent's denials of Petitioners' requests for additional Enhanced Pharmacy items and skilled therapies are **REVERSED** and it must initiate a reassessment of Petitioners' requests.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioners 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).

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