[redacted]

Date Mailed: January 11, 2023
MOAHR Docket No.: 22-005290
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 January 5, 2023. [redacted] Petitioner's mother, appeared and testified on Petitioner's behalf. [redacted] Petitioner and Dr. Tim Evans, Program Director and Case Manager, appeared as witnesses for Petitioner.

George Motakis, Chief Compliance Officer, appeared on behalf of Respondent, Lakeshore Regional Entity, the PIHP for Network 180 (Respondent, LRE, or Network 180). John Stitzel, Utilization Management (UM) Review Specialist, appeared as a witness for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for continued Targeted Case Management (TCM)?

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 who has been receiving services through Respondent. (Exhibit B; Testimony)

2. In September 2022, while reviewing Petitioner's 3-month authorization for TCM, Respondent concluded that Petitioner no longer met the medical necessity criteria for continued TCM because Petitioner had made noted improvements while receiving TCM. (Exhibit B, pp 5-20; Testimony)

3. Respondent also noted that it had requested that the TCM provider step Petitioner down from TCM during the prior two 3-month authorizations

because Petitioner was doing so well. (Exhibit B, pp 5-20; Testimony)

4. On September 23, 2022, Respondent sent Petitioner a Notice of Adverse Benefit Determination (NABD) informing Petitioner that his request for 36 units of TCM for the period of October 6, 2022 through January 6, 2023 was denied, but that 12 units of TCM and 1 unit of Medication Review were approved for one month, from October 6, 2022 through November 6, 2022, to allow Petitioner to transition to a lower level of care, such as outpatient counseling and psychiatry. (Exhibit B, pp 1-4; Testimony)

5. On October 15, 2022, Petitioner requested an Internal Appeal. (Exhibit A; Testimony)

6. On October 27, 2022, after reviewing Petitioner's appeal, Respondent sent Petitioner a Notice of Appeal Denial, which upheld the original findings. (Exhibit C; Testimony).

7. On November 7, 2022, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit E)

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Respondent contracts with MDHHS to provide specialty mental health services. Services are provided by Respondent pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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.

July 1, 2022, pp 12-14

Case Management services are also defined in the Medicaid Provider Manual:

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. 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.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports.

Justification as to whether case management is needed or not must be documented in the beneficiary's record.

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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2022, pp 96-97

Respondent's UM Review Specialist (UMRS) testified that he is a licensed professional counselor and has worked in the mental health field since 2005. Respondent's UMRS reviewed the purpose of TCM as outlined in the above policy as well as the meaning of medical necessity, also outline above. Respondent's UMRS testified that upon reviewing Petitioner's authorization request for 36 units of TCM, he looked at Petitioner's most recent CAFAS score and the provider's notes regarding Petitioner's progress. Respondent's UMRS noted that Petitioner's CAFAS score was 50, which showed mild impairment in most areas and Petitioner's progress notes showed that he was doing well. Specifically, Respondent's UMRS noted that Petitioner's progress notes showed that he had done well in his first three weeks of high school, was planning on starting a job soon, was eating and sleeping well, and was showing no side effects from his medications. Respondent's UMRS noted that while Petitioner was still having

some difficulty with his sister at home, he no longer met medical necessity criteria for TCM, and outpatient counseling would be the most appropriate level of care going forward. Respondent's UMRS also noted that Respondent had recommended to Petitioner's TCM provider that it step-down Petitioner from TCM at the past two authorization periods, but the provider had not done so. Respondent's UMRS testified that if Petitioner's condition has worsened since the September 2022 assessment, he can always request a new assessment and determination.

Petitioner's mother testified that she was devastated when she received notice that Petitioner was being removed from TCM. Petitioner's mother indicated that right around the time she received the notice, Petitioner began having trouble at school. Petitioner's mother testified that while the first couple of weeks of high school went okay for Petitioner, things started going downhill after that. Petitioner's mother indicated that she began receiving calls from the school every day regarding Petitioner's behaviors, which included leaving class and yelling at other kids. Petitioner's mother testified that Petitioner tried sports but had to leave because of issues with other students and coaches. Petitioner's mother indicated that Petitioner has trouble controlling his emotions.

Petitioner's mother testified that the school completed an IEP and provided many accommodations to Petitioner, such as allowing him to leave class to go see a counselor and having a separate room to take tests. Petitioner's mother indicated that Petitioner still freaks out with his sister and throws things. Petitioner's mother testified that this has all been too much for Petitioner at once and he started regressing as soon as he learned he was going to leave TCM. Petitioner's mother noted that it takes Petitioner a long time to get comfortable with new things and he barely passed his classes the first semester.

Petitioner's case manager testified that he believes Network 180 does a fantastic job and noted that most of the current issues with Petitioner came up after the September review. Petitioner's case manager noted that Petitioner was nervous about high school before the NABD was received but things began to unravel quickly after that. Petitioner's case manager indicated that Petitioner's CAFAS score is now up to 60 to account for the difficulty he has been having at school. Petitioner's case manager testified that Petitioner has stable relationships with his mother and sister, but that school is the biggest concern at this time. Petitioner's case manager also noted that Petitioner had difficulty with the sports he tried as he has challenges with authority figures. Petitioner's case manager testified that Petitioner's medications were recently changed and noted that Petitioner now has five different mental health diagnoses.

Petitioner testified that working with his case manager has been very helpful and he believes he will go downhill if he is not allowed to continue.

Based on the evidence presented, Respondent properly denied Petitioner's request for continued TCM services at the time the decision was made. As indicated, TCM is intended for children with serious emotional disturbance, persons with a developmental disability, and those 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. Here, the evidence available to Respondent at the time the decision was made showed that Petitioner's CAFAS score was 50, showing mild impairment in most areas, Petitioner had done well in his first three weeks of high school, was planning on starting a job soon, was eating and sleeping well, and was showing no side effects from his medications. It was also noted in the progress reports that Petitioner's mother reported Petitioner was doing well at home. As such, Petitioner did not show a need for TCM at the time the decision was made because he had improved to a point where he did not meet the above medical necessity criteria for someone to receive TCM. Furthermore, it appears that Petitioner had been stable for some time given that Respondent had recommended to Petitioner's TCM provider that it step-down Petitioner from TCM at the past two authorization periods, but the provider had not done so.

Since it does appear that Petitioner may have regressed some since the decision was made, he should request that his need for TCM be reevaluated. However, based on the evidence presented, Petitioner has failed to prove, by a preponderance of the evidence, that the Respondent erred in denying continued TCM services at the time the decision was made.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent properly denied Petitioner's continued Targeted Case Management services.

IT IS THEREFORE ORDERED that:

The Respondent's decision is AFFIRMED.

RM/sj

Robert J. Meade
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

Via Electronic Mail:

DHHS Department Representative
George V. Motakis- 61
Community Mental Health/OnPoint
Chief Compliance Officer
Norton Shores, MI 49441
Georgem@lsre.org

DHHS Department Contact
Belinda Hawks
320 S. Walnut St.
Lansing, MI 48913
MDHHS-BHDDA-Hearing-Notices@michigan.gov

Via First Class Mail:

Authorized Hearing Representative
[redacted]

Petitioner
[redacted]