Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: July 9, 2025
Docket No.: 25-014359
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: July 9, 2025
Docket No.: 25-014359
Case No.: 88739949
Petitioner: [redacted]

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 July 1, 2025.

Petitioner appeared and testified on his own behalf. [redacted] Petitioner's therapist, testified as a witness for Petitioner.

George Motakis, Compliance Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Kelsey Wright, a Utilization Review Specialist at Network 180, testified as a witness for Respondent.

During the hearing, the following exhibits were entered into the record without objection:

Exhibit A: January 28, 2025, Letter of Adverse Benefit Determination

Exhibit B: February 5, 2025, Request for Appeal

Exhibit C: February 7, 2025, Notice of Receipt of Appeal

Exhibit D: February 18, 2025, Notice of Appeal Denial

Exhibit E: Appeal Summary Report

Exhibit F: April 22, 2025, Request for State Fair Hearing

Exhibit G: May 1, 2025, Notice of Hearing

Exhibit H: Kelsey Wright Credentials

Exhibit I: Michelle Anguiano Credentials

ISSUE

Did Respondent properly deny reauthorization of Petitioner's targeted case management 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 Medicaid beneficiary who has been receiving Targeted Case Management services from the Respondent since 2015. (Exhibit A, pages 11, 22-23, 31).

2. On January 28, 2025, the Respondent sent Petitioner a Adverse Benefit Determination. The noticed provided the following:

> You asked for twelve (12) months of Targeted Case Management. Your goals were to continue working on helping your mental health symptoms. You have a therapist, and you are taking medications as prescribed. Targeted Case Management is no longer medically necessary. This service will end on 5/1/2025. Your goals can be supported with a lower level of care. You can continue to receive therapy and medication management.[1]

3. On February 6, 2025, Respondent received from Petitioner, a request for appeal. (Exhibit C.)

4. On February 18, 2025, the Respondent sent Petitioner a Letter of Appeal Denial. The letter provided the following:

> Your targeted case management (TCM) services ended. Your case was reviewed. You show that your symptoms are well managed on medications. You have not been hospitalized recently for your mental health. You deny suicidal and homicidal thoughts. You deny any psychosis. There are no identified risk factors related to abuse/violence, housing, or financial insecurities. You have no current legal issues. There is no evidence that you have any daily needs that require the support of case management services. Per the Michigan Medicaid Manual, you no longer meet medical necessity for TCM and will be offered a 3-month transition

[1] Exhibit A, p 1.

> authorization which will expire on 5/1/2025. The recommended level of care following this period would be outpatient therapy and outpatient medication management. Your appeal is denied.[2]

5. On April 22, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit F.)

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.[3]

> 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.[4]

[2] Exhibit D, p 1.
[3] 42 CFR 430.0.
[4] 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…[5]

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 targeted case management services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> 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

[5] 42 USC 1396n(b).

> 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.
>
> * * *
>
> **13.2 DETERMINATION OF NEED**
>
> The determination of the need for case management/supports coordination 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/supports coordination is needed or not must be documented in the beneficiary's record. Beneficiaries must be provided choice of available, qualified case management/supports coordination staff upon initial assignment and on an ongoing basis.[6]

Moreover, while targeted case management services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[7] Regarding 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:

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2025, pp 105-106.
[7] *See* 42 CFR 440.230.

- 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.[8]

Here, as discussed above, Respondent denied Petitioner's request to reauthorize targeted case management services pursuant to the above policies and on the basis that the services were no longer medically necessary.

[8] MPM, Behavioral Health and Intellectual and Developmental Disability Supports, January 1, 2025, pp 13-15.

In appealing that decision, 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 it 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 failed to meet his burden of proof; and that Respondent's decision must therefore be affirmed.

Petitioner was previously approved for targeted case management services, but that alone is not enough to demonstrate a continuing need for the services; and as credibly and fully explained by Respondent's witnesses, targeted case management services were no longer necessary given Petitioner's improvement and access to outpatient services.

In particular, those witnesses noted that Petitioner has been stable at his baseline; there has been no hospitalizations, self-harm or delusions; and he has stable housing.

Moreover, while both Petitioner and his witness credibly testified as to how targeted case management has assisted Petitioner in the past, as well as their fears that Petitioner will regress without them; they did not establish that the services are currently needed, as opposed to simply being beneficial; and the undersigned Administrative Law Judge does not find them medically necessary given Petitioner's improvement, his demonstrated abilities, and other available resources.

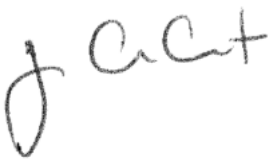
To the extent Petitioner's circumstances change or he has additional or updated information to provide regarding his need for targeted case management, then Petitioner can always request such services again in the future along with that information. With respect to the decision at issue in this case; however, Respondent's decision must be affirmed given the available information and applicable policies.

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 reauthorization of targeted case management services.

IT IS THEREFORE ORDERED that:

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



COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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