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

Date Mailed: July 29, 2025
Docket No.: 25-019434
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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这是一份重要的法律文件。请让别人翻译文件。

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

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Docket No.: 25-019434
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on July 2, 2025. Joshua May, Petitioner's Case Manager at Network 180, appeared and testified on Petitioner's behalf. Petitioner also testified as a witness on her own behalf. George Motakis, State Fair Hearings Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Kelsey Wright, a Utilization Review Specialist at Network 180, also testified as a witness for Respondent.

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

Exhibit A: Notice of Adverse Benefit Determination and Appeal Packet

Exhibit B: Appeal Request

Exhibit C: Notice of Receipt of Appeal

Exhibit D: Notice of Appeal Denial

Exhibit E: Appeal Summary Report

Exhibit F: Request for State Fair Hearing

Exhibit G: Notice of Hearing

Exhibit H: Credentials for Kelsey Wright

Exhibit I: Credentials for Michelle Anguiano

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 [redacted] Medicaid beneficiary who has been diagnosed with major depressive disorder, recurrent moderate; post-traumatic stress disorder; borderline personality disorder; and an unspecified anxiety disorder. (Exhibit A, pages 11, 13, 26).

2. Due to the symptoms and effects of her diagnoses, she has been hospitalized 4 times. (Exhibit A, page 15).

3. The last psychiatric hospitalization was in 2015. (Exhibit A, page 15).

4. Since 2021, Petitioner was approved for services through Respondent, a Prepaid Inpatient Health Plan (PIHP), and its associated Community Mental Health Service Providers (CMHSPs), with services through the Hope Network until 2023 and Network 180 since that time. (Exhibit A, pages 13-14; Testimony of Respondent's representative; Testimony of Utilization Review Specialist).

5. As part of her services, Petitioner received targeted case management services at Network 180. (Exhibit A, pages 13-14).

6. She is also approved for supported employment, since losing her job in December of 2024; weekly therapy; and medication reviews. (Exhibit A, pages 13-14).

7. In a Biopsychosocial Assessment completed on February 7, 2025, it was noted that Petitioner lives in a private residence; she receives food stamps; her medications are working well; and she is able to utilize transportation and access the community (Exhibit A, pages 17, 2224)

8. It also identified Petitioner's symptoms as including emotional dysregulation; difficulties maintaining appropriate expectations and boundaries in her significant relationships; and handling clinical and administrative tasks effectively. (Exhibit A, page 27).

9. Petitioner also reported continuing troubles with comprehension, reading things on her own, and managing paperwork. (Exhibit A, pages 15, 26).

10. On March 7, 2025, she completed renewal paperwork required by the Department of Health and Human Services (DHHS) with her case manager. (Exhibit A, page 38).

11. At that time, she also reported working with supported employment; being compliant with her medications; and that she was doing well. (Exhibit A, page 38)

12. Petitioner did request another twelve (12) months of targeted case management services through Network 180 and Respondent. (Exhibit A, page 27; Testimony of Utilization Review Specialist).

13. On March 19, 2025, Network 180 sent Petitioner a Notice of Adverse Benefit Determination stating that Petitioner's request for targeted case management services had been partially denied. (Exhibit A, pages 1-9).

14. The Notice of Adverse Benefit Determination also stated in part:

> You asked for twelve (12) months of Targeted Case Management. Your goals were to continue working on helping your mental health symptoms. You are taking your medications. You are going to therapy. Targeted Case Management is no longer medically necessary. This service will end on 6/19/2025. Your goals can be supported with a lower level of care. You can continue to receive medication management and therapy. Please contact your current Case Manager with questions.
>
> * * *
>
> The clinical documentation provided does not establish medical necessity.

Exhibit A, page 1

15. On April 2, 2025, Petitioner filed an Internal Appeal with Respondent regarding the decision to partially deny the request for reauthorization of targeted case management. (Exhibit B, pages 1-4; Exhibit C, pages 1-4).

16. In that Internal Appeal, Petitioner wrote that she still utilizes case management services for assistance with employment, medication management, benefits coordination, and housing assistance. (Exhibit B, page 1).

17. On April 22, 2025, Respondent sent Petitioner a Notice of Appeal Denial. (Exhibit D, pages 1-6).

18. With respect to the reason for the denial, the notice stated in part:

> Your Internal Appeal was denied for the service(s)/item(s) listed above because:
>
> You asked for twelve (12) months of Targeted Case Management. Your goals were to continue working on helping your mental health symptoms. You are taking your medications. You are going to therapy. TCM is no longer medically necessary. The service will end on 6/19/2025. Your goals can be supported with a lower level of care. Your appeal has been denied.

Exhibit D, page 1

19. On May 23, 2025, MOAHR received the request for hearing filed by Petitioner in this matter regarding targeted case management services. (Exhibit F, pages 1-4).

20. Since the decision at issue in this case was made, Petitioner has been unable to access approved therapy and medication management services due to a lack of providers. (Testimony of Petitioner; Testimony of Petitioner's representative).

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 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 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.

MPM, January 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 103-104

Moreover, while targeted case management services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. 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:

- 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, January 1, 2024 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 13-15*

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.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ 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 ALJ finds that Petitioner has failed to meet her 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; stability in the community; and her other approved services, including therapy and medication management services.

In response, Petitioner testified that she still needs help with paperwork; she has no other supports; and that she needs help to maintain her housing and food. However, Petitioner is presenting at her baseline; she has not had any recent psychiatric hospitalizations; her housing is stable; and she has been approved for food stamps. Petitioner's testimony demonstrates that her services have been beneficial, but not that they are medically necessary given Petitioner's improvement, her demonstrated abilities, and other available resources.

Moreover, while both Petitioner and her representative/case manager credibly testified as to issues Petitioner has had since the decision at issue in this case; in continuing with her approved therapy and medication management services, the undersigned ALJ is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

To the extent Petitioner's circumstances have changed or she has additional or updated information to provide regarding her 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**.

Steven Kibit

STEVEN KIBIT
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 LARA-MOAHR-DCH@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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