STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2009–36848 SAS
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted], administrative hearings officer, represented the Department. Her witnesses included [redacted], utilization coordinator, and [redacted], medical director.

ISSUE

Did [redacted] properly deny Opioid Maintenance Treatment (OMT) to the Appellant?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant, as a self-pay, has been receiving OMT (methadone treatment) through the [redacted] from [redacted], through [redacted]. (*See* Testimony and Department's Exhibit N, throughout)

3. Appellant presents as a person with a significant addiction and treatment history. The Appellant said she can no longer afford to pay for OMT out of pocket owing to family obligations. (Appellant's Exhibit #1, Department's Exhibit A-O and *See* Testimony of the Appellant)

4. Following a chart review of the threshold decision to deny, Medical Director [redacted] confirmed the original conclusion that the Appellant did not meet medical necessity standards for methadone dosing – however the reviewers at [redacted] did approve detoxification and SUD residential services. (*See* Testimony and Department's Exhibit A, G, O)

5. [redacted] testified that achieving a drug-free life style would be a better alternative for the Appellant as opposed to switching from one drug to another, although he allowed that the program could work with the Appellant to fine tune her OMT taper if she agreed to [redacted] recommendation. (*See* Testimony of Dr. Baker)

6. The Appellant was notified of her denial in writing on [redacted], wherein the results of [redacted] analysis and recommendation for detoxification and residential treatment were explained. Her further appeal rights were explained therein. (Department's Exhibit H, p. 51)

7. At hearing the parties, on their own initiative, discussed a compromise treatment plan. Neither SOAHR nor the ALJ suggested such a resolution. (*See* Testimony)

8. The instant request for hearing was received by the State Office of Administrative Hearings and Rules (SOAHR) on [redacted]. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medicaid program was established pursuant to Title XIX of the Social Security Act (SSA) and is implemented by 42 USC 1396 *et seq*., and Title 42 of the Code of Federal Regulations (42 CFR 430 *et seq*). The program is administered in accordance with state statue, the Social Welfare Act (MCL 400.1 *et seq*), various portions of Michigan's Administrative Code (1979 AC, R400.1101 *et seq*), and the state Medicaid plan promulgated pursuant to Title XIX of the SSA.

Subsection 1915(b) of the SSA provides, in relevant part:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C)) as may be necessary for a State –
>
> (1) to implement a primary care case-management system or a specialty physician services arrangement, which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in

> emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary.
>
> Under approval from the Center of Medicare and Medicaid Services (CMS), the Department (MDCH) presently operates a Section 1915(b) Medicaid waiver referred to as the managed specialty supports and services waiver. A prepaid inpatient health plan (PIHP) contracts with MDCH to provide services under the waiver, as well as other covered services offered under the state Medicaid plan.
>
> Pursuant to the Section 1915(b) waiver, Medicaid state plan services, including substance abuse rehabilitative services, may be provided by the PIHP to beneficiaries who meet applicable coverage or eligibility criteria. *See* Contract, Part II, Section 2.1.1, p. 23. Specific service and support definitions are set forth in the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual (MPM).
>
> Contractually, the PHIP must limit Medicaid services to those that are medically necessary and appropriate, and that conform to accepted standards of care. *See generally* 42 CFR 440.230.

The definition for Medical necessity [found in the MPM] is used under the Contract:

> **MEDICAL NECESSITY CRITERIA**
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **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.
>
> *See* Contract, Part II, §3.2 p. 32[1]

[1] Refers the reader back to the MPM at §2.5, 2.5A, Mental Health/Substance Abuse, 10-1-09, pp. 12-13

Furthermore, the MPM establishes that the following Medicaid-covered substance abuse services and supports must be provided, based on medical necessity, to eligible beneficiaries:

SUBSTANCE ABUSE SERVICES

[ ] COVERED SERVICES - OUTPATIENT CARE

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services.

Outpatient treatment is a non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination.

Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge.[2]

[ ] ELIGIBILITY

Outpatient care may be provided only when:

- The service meets medical necessity criteria.
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes.
- The service is based on individualized determination of need.
- The service is cost effective.

[2] This edition of the MPM is identical to the version in place at the time of appeal.

- The American Society of Addiction Medicine (ASAM) Patient Placement Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Patient Placement Criteria [:]
- Withdrawal potential
- Medical conditions and complications
- Emotional, behavioral or cognitive conditions and complications
- Readiness to change
- Relapse, continued use or continued problem potential
- Recovery/living environment.

This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:

- an acceptable readiness to change level;
- minimal or manageable medical conditions;
- minimal or manageable withdrawal risks;
- emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- minimal or manageable relapse potential; and
- a minimally to fully supportive recovery environment.

[ ] COVERED SERVICES

Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

Detoxification/Withdrawal Monitoring

For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.

. . . . [majority of listing under this section omitted by the ALJ]

Substance Abuse Treatment Services

Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, and treatment based on medical necessity. They may include individual, group and family treatment. These services are provided under the supervision of a SATS or SATP.

[ ] ADMISSION CRITERIA

Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently.

Reauthorization of services can be denied in situations where the beneficiary has:

- not been actively involved in their treatment, as evidenced by repeatedly missing appointments;
- not been participating/refusing to participate in treatment activities;
- continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services.

Beneficiaries may also be terminated from treatment services based on these violations.

[ ] SERVICE INTENSITY

The medically necessary outpatient services correspond to the frequency and duration of services established by the ASAM levels of care and are referred to as follows:

- Level 0.5 – Early Intervention
- Level I.0 – Outpatient
- Level II.1 – Intensive Outpatient
- Level II.5 – Expanded Intensive Outpatient

Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/ duration of services may be utilized if these are medically necessary. The ASAM levels correspond with established hours of services that take place during a week.

ASAM Level 0.5 Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.

ASAM Level I.0 Services from one hour to eight hours during a week.

ASAM Level II.1 Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment.

ASAM Level II.5 Services that are offered 20 or more hours in a week.

[ ] OFFICE OF PHARMACOLOGICAL AND ALTERNATIVE THERAPIES/CENTER FOR SUBSTANCE ABUSE TREATMENT (OPAT/CSAT) APPROVED PHARMACOLOGICAL SUPPORTS

Covered services for Methadone and pharmacological supports and laboratory services, as required by OPAT/CSAT regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests
- TB skin test (as ordered by physician)

Opiate-dependent beneficiaries may be provided chemotherapy using methadone as an adjunct to therapy. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration (DEA).
- Methadone must be administered by an MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

- MDCH Enrollment Criteria for Methadone Maintenance and Detoxification Program (attached to the MDCH PIHP contract) must be followed.

[ ] EXCLUDED SERVICES

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification.
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM).
- Medications used in the treatment/management of addictive disorders.
- Emergency medical care.
- Emergency transportation.
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
- Routine transportation to substance abuse treatment services which is the responsibility of the local DHS.

MPM, Mental Health/Substance Abuse, §12 *et seq.,* pp. 62-66, October 1, 2009

***

The Department witnesses testified that their decision relied on the utilization review indicating no medical necessity for OMT. All of this material was reviewed by [redacted] medical director [redacted] – including the Appellant's recent self-pay OMT treatment at [redacted]). [redacted] agreed with the utilization reviewers that the Appellant had not demonstrated medical necessity and testified that switching one drug for another was not a good long term strategy in her case.

He reiterated the recommendation of the utilization reviewers that detoxification and Substance Use Disorder (SUD) residential treatment remained the Appellant's best treatment option – an offer which remained open at the time of hearing.

The core of the Appellant's testimony centered on the idea that she was new to OMT and the department's projected schedule would guarantee failure – given her long standing polysubstance abuse and addiction(s). She said that she believed it was possible that she might have to stay on OMT for the rest of her life – irrespective of her medical issues – most notably a pre-existing liver problem[3]. The Appellant further testified that she is concerned for her ability to maintain self-pay OMT status owing to limited financial resources and child care.

On his own motion [redacted] volunteered that [redacted] could accommodate the Appellant with a more refined and tapered enrollment plan. The Appellant expressed interest – but did not withdraw her appeal.

The Department witnesses provided adequate documentary evidence and testimony to prove that its denial of OMT was proper and in accordance with Department policy.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for OMT.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/9/2009

[3] *See* Dr. Baker's letter at Ex. O, pp. 131-2

***** NOTICE*****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision & Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.