STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-52510 CMH
Case No. 16994423

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted], and continued until [redacted]. [redacted] appeared on behalf of the Appellant. His witnesses were [redacted] and [redacted]; [redacted]; and [redacted].

[redacted], represented the Department. Her witnesses were [redacted], and [redacted].

Also in attendance was personal aide to the Appellant, [redacted].

PRELIMINARY MATTER

This ALJ did not request a written Request for Findings of Fact and Rulings of Law from the Appellant, but rather as his own document suggests this emanated from a prior hearing held under Docket No. 2010-41100 CMH on [redacted]. Nevertheless, without objection, this writing was accepted as the Appellant's written closing.

APPELLANT'S EXHIBITS

Exhibit #1 Request for Hearing, [redacted]
Exhibit #2 Correspondence to the State Office of Administrative Hearings and Rules (SOAHR) requesting telephone appearance of witnesses granted by ALJ Isiogu, [redacted].
Exhibit #3 Appellant notice, proposed witness list, and sub-exhibits 1 – 36.
1) [redacted] History of Admissions
2) Nursing notes [redacted]
3) [redacted] progress notes dated [redacted]

4) [redacted] Medical documents showing PEDS ICU admission [redacted]
5) [redacted] progress notes
6) [redacted] Department of Psychiatry [redacted]
7) [redacted] PEDS [redacted]
8) Michigan Department of Community Health, Children's Special Health Care, Eligibility Notice
9) [redacted] report dated [redacted]. "I concur with the treatment plan as described including the frequency of ECT at three times per week. Please refer to utilization management criteria, Community Behavioral Health Michigan, [redacted], outpatient treatment criteria are met. In my opinion the patient meets medically necessary criteria for outpatient Mental Health and ECT"
10) Progress notes from [redacted]
11) Correspondence representing transition for [redacted] to [redacted]
    a) [redacted] Medical Order from [redacted] "Avoid all Neuroleptic medications due to history of Neuroleptic Malignant Syndrome."
12) Person Centered Planning [redacted]
13) The [redacted] Advance Action Notice dated [redacted] [see Ex. 29]
14) [redacted] CMH IPOS, [redacted]
15) [redacted] CMH rough draft of IPOS
16) [redacted] correspondence from [redacted] by her guardian.
17) [redacted] CMH Preliminary Plan Addendum, [redacted]
    a) Fax to [redacted] case manager [redacted] CMH
18) Prescription from [redacted] CMH Psychiatrist
19) [redacted] CMH psychiatric evaluation [redacted]
20) [redacted] psychiatric evaluation for [redacted] CMH. Date of evaluation [redacted]
21) [redacted] CMH Behavior Plan draft, [redacted]
22) [redacted] CMH Annual Assessment prepared by new case worker [redacted]
23) [redacted], [redacted] correspondence and prescription from [redacted]
24) [redacted], correspondence from [redacted]
25) [redacted], correspondence from [redacted]
26) Correspondence to [redacted] hand delivered, [redacted]
27) [redacted] CMH Individual Plan of Service, [redacted]
28) Billing documents from the [redacted] hospital regarding ECT treatments
29) Dismissal Order, Docket #2010-41100 CMH
30) [redacted] CMH Affiliation PIHP policy manual supplied to [redacted] as ordered by the ALJ at the [redacted] hearing
31) The MPM §2.6 ECT

32) [redacted] correspondence dated [redacted]
33) A fax cover sheet from [redacted] hospital to [redacted] CMH dated [redacted] first request for patient records
34) Letter from [redacted] and [redacted]
35) Progress note from [redacted] Hospital ECT clinic [redacted], outline of total ECT treatments for [redacted]
36) Temporary letters of Guardianship

Exhibit #37 [redacted] Hospital medical record – diagnosis: Schizophrenia[1]
Exhibit #38 Case study *Catatonia: Clinical Aspects and Neurological Correlates*
Exhibit #39 Case Report *ECT Treatment of Malignant Catatonia/NMS in an Adolescent: A Useful Lesson in Delayed Diagnosis and Treatment,* by Dr. Neera Ghaziuddin, M.D., Iyad Alkhouri, M.D., Donna Champine, M.D., Paul Quinlan, D.O., Thomas Fluent, M.D., and Mohammad Ghaziuddin, M.D.
Exhibit #40 No exhibit offered
Exhibit #41 No exhibit offered
Exhibit #42 Billings for ETC from the [redacted] Department of Psychiatry

DEPARTMENT'S EXHIBITS

Exhibit A Hearing summary, pp. 1, 2
- Exhibit sub (A) Advance Action Notice, p. 3
- Exhibit sub (B) Letters of Guardianship, pp. 4, 5
- Exhibit sub (C) Individual Plan of Service, [redacted], pp. 6-16
- Exhibit sub (D) Medicaid Provider Manual (MPM), §1.7, Mental Health [ ], July 1, 2010, pp. 17, 18
- Exhibit sub (E) MPM §2.5 *Supra,* pp. 19-21
- Exhibit sub (F) Authorizations by auth number
- Exhibit sub (G) [redacted] CMH psychiatric evaluation [redacted] pp. 23, 24
- Exhibit sub (H) DSM IV 296.90 Mood Disorder, NOS
- Exhibit sub (I) Prescription from [redacted] CMH Psychiatrist.
- Exhibit sub (J) Northwest CMH Affiliation PIHP policy manual, pp. 27 – 29
- Exhibit sub (K) Symposium 2. ECT in Special Populations…pp. 30-32
- Exhibit sub (L) Neuroleptic Malignant Syndrome *E*medicine, May 7, 2010, pp. 33-50

ISSUE

Did the Department properly suspend Electro-Convulsive Therapy for the Appellant?

[1] Admitted over objection for lack of relevance. Subject to weight given date of record [redacted].

FINDINGS OF FACT

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

1. The Appellant is [redacted] Medicaid and SSI beneficiary. (Appellant's Exhibit #1)

2. The Appellant is diagnosed [variously] with: Mood disorder, NOS, Disruptive Behavior. Neuroleptic Malignant Syndrome (NMS), Malignant Catatonia, Autism, Major Depressive Disorder, Severe MR, Rhabdomyolysis, Right middle lobe Pneumonia, Seizure disorder, Malignany [sic] Catatonia. (Appellant's Exhibit #3 (12) and Department's Exhibit A, p.1)

3. The Appellant's [redacted] is her guardian. (Appellant's Exhibit #3 (36) and Department's Exhibit A (B), pp. 4, 5)

4. The Appellant lived in [redacted] County until [redacted] when the family moved to [redacted] County. (Appellant's Exhibit #3 (11))

5. The Appellant was discharged from [redacted] County mental health jurisdiction on [redacted], with [redacted] Community Mental Health Authority ([redacted] CMHA) jurisdiction beginning on [redacted]. *See* Testimony of [redacted], [redacted].

6. The service provider, [redacted], has received no payment for ECT services. (Appellant's Exhibit #3 (42) and See Testimony of [redacted], patient account representative, the [redacted], Department of Psychiatry)

7. The Department took program jurisdiction over the Appellant on [redacted]. (Appellant's Exhibit #3 (14))

8. The Appellant requires an array of services including: DHS chore services, CLS, Respite, monitoring, home alarms, annual camp, medications and ECT. (Department's Exhibit A (C), pp. 7-16)

9. On [redacted], the Appellant was provided with notice that heretofore recommended ECT was suspended effective [redacted]. (Department's Exhibit A (A), p. 3)

10. On [redacted], the Department's psychiatrist, [redacted] executed a psychiatric evaluation letter wherein he confirmed the Appellant's above listed diagnoses and stated: "The primary purpose of this evaluation was to review notes and to be able to sign off on ECT as prescribed by [redacted] physican for [redacted] and there were no other psychiatric issues at this point in time….PLAN: 1. Medications: At this point in time I agree with [redacted] and

> also [redacted]'s psychiatrist [redacted], that [redacted] [a psychiatrist] should continue to manage her medication treatment with [redacted].... Makes more sense especially in terms of also ECT and I also agree that ECT should continue to be authorized through CMH here as prescribed by [redacted]... I will continue to let [redacted] manage this patient and approve of ECT payment through our CMH system here. Signed [redacted]." *See* Department's Exhibit A (G), pp. 23, 24 and Appellant's Exhibit #3 (19).

11. In its notice the Department stated that the ECT was "Suspended [...because] Medical Necessity Criterion has not been evidenced in [redacted]CMH'S psychiatric evaluation." (Department's Exhibit A, p. 1)

12. The Department representative also stated that the ECT was denied owing to concerns about the limits of the Appellant's guardianship, and a prohibition against ECT for behavior control and as part of the PIHP decision making process under the MPM. *See* Closing of [redacted].

13. The instant appeal was received by the State Office of Administrative Hearings and Rules on [redacted].

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

[2] The Appellant's representative asks that the ALJ observe that his copy of this letter [at Appellant's Ex. #3 (19)], received from the Department, was not executed. The ALJ observes that fact - as well as the omission of a signature date. I conclude this was a print-execution-error of no actual consequence.

> 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 Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. [redacted]CMHA contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by the Authority 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.

As a person afflicted with a serious mental illness and a developmental disorder the Appellant is entitled to receive services from the NLCMHA. *See* Medicaid Provider Manual, (MPM) Mental Health [ ], Beneficiary Eligibility, §1.6, January 1, 2011, pp. 3, 4 and MCL 330.1100d(3). However, the construction of those services and supports are not static, but rather subject to review by mental health professionals confirming that a current functional impairment and a current medical necessity exists for receipt of those specialized services and supports.

While it is axiomatic that services are coordinated between agencies and counties the [redacted]CMHA remains the entry point for treatment of mental illness, developmental disability or substance abuse. The service criteria for this capitated provider is <u>medical necessity</u> under the Medicaid Provider Manual:

> Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is

consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

MPM, *Supra* §1.7, p. 5

* * *

MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

*** * ***

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.

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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. (Emphasis supplied)
>
> MPM, *Supra*, §§2.5 – 2.5.D, pages 13, 14.

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The Department representative, [redacted] summarized the Department's position on opening of proofs stating that Electro-Convulsive therapy (ECT) was viewed by the Department as a necessary treatment for the Appellant in [redacted] – when her condition was emergent – but that now owing to her improved condition ECT was viewed by the CMH as behavior modification – prohibited under policy.

The preponderating evidence – much of it from the Department itself – did not support this conclusion, but rather gave weight to the ALJ's conclusion that the Department was attempting to cost-shift its financial responsibility.

In total there were at least four physican reviewers [in this record] concurring in the decision to administer ECT. (Appellant's Exhibit #3 at (9), (18), (19), (34) and *See* Testimony of [redacted])

The Department's first witness, [redacted], testified that she was not the originally assigned Case Manger for the Appellant. She described the array of services approved for the Appellant including behavior plan, building alarms, DHS chore services, CLS, respite and staff for community outings. She characterized the request for ECT as "unusual."

She testified that ECT was part of the plan of service which was approved and executed by the Appellant's representative – although on cross examination he noted that his hand written amendments were not produced on the executed copy of the agreement.

[redacted] testified that the order of interaction from on-site staff with the Appellant would necessarily range from verbal reminders, to redirection, to physical intervention - in an emergency situation.

She testified that the suspension of reimbursement or payment for ECT was owing to the prospect for behavioral modification prohibited under policy. [The Department cites Ex. J for evidence of this prohibition]

Although she acknowledged that the Appellant was a consumer of [redacted] CMHA in [redacted] she testified that her first contact[3] with the Appellant – via her representative - was by telephone on [redacted]. She said an IPOS was prepared and executed one month later.

The Department's last witness, [redacted], testified that on review by her and with the [redacted] CMHA Chief Executive Officer[4] it was determined that payment would not be authorized because the ECT was not "medically *indicated*." She said ECT, in this case, was utilized for behavior modification.

This analysis took place following the second psychiatric review as conducted by [redacted] CMHA psychiatrist, [redacted], who broadly supported psychiatrist [redacted] and her recommended treatment plan, medication plan and "approve[d]" payment from [redacted] CMHA.

[redacted] said that she did not see catatonic behavior in the Appellant.

The Appellant's witness, [redacted], testified that the Appellant, afflicted with autism since age three, suffered from Neuroleptic-malignant syndrome (NMS)[5] as a reaction to certain medications she was taking in [redacted] for other medical reasons.

Near death the Appellant was placed in pediatric ICU where ECT was administered. She had a rapid response relieving her fever and lowering her highly elevated CPK levels. She said that the Appellant was violent and agitated for a two-week period in [redacted] – until they were able to titrate her ECT to achieve a workable level that required weekly adjustment depending on her clinical presentation. She said that the Appellant suffered a significant loss of cognitive function. She then explained that NMS is a medical syndrome - as opposed to her catatonia and that she remains at risk for developing another violent and life threatening episode - in addition to being exquisitely sensitive to redeveloping catatonia.

She said that discontinuing ECT was not in the Appellant's best interest. She said there would be a rapid deterioration of the Appellant's condition leading to institutionalization. The doctor concluded her testimony stating that the Appellant's best and least restrictive environment was at home with her father and family. Discontinuance of ECT, according to [redacted], would cause her catatonia to increase and that other changes would include aggressiveness, changed behavior, inappropriate disrobing, not chewing, swallowing difficulty – resulting in

[3] She replaced [redacted] previous [redacted] CMHA case manager.
[4] The CEO did not testify.
[5] A complication of Catatonia. See *Use of ECT in Adolescents,* by Neera Ghaziuddin, M.D., University of Michigan, 2001, Department's Ex. A (K) pp. 31, 32

removal from the home and institutionalization. She added then that depending where she was placed a potential for misdiagnosis would persist – owing to the presentation of symptoms leading to over-medication, further hospitalization and "…ECT again anyway."

Clearly, [redacted] stated intention is not to inhibit behavior, but rather to manage symptoms – as they are part of the illness [NMS].

[redacted], the [redacted] CMHA psychiatrist, agreed with [redacted] various diagnoses, medication recommendations, [including ECT], in amount, scope, duration and authorization for payment from [redacted] CMHA. *See* Department's Exhibit A (G) and Appellant's Exhibit #3 (19).

Importantly each physican referenced in this record recognized the Appellant's behaviors or "behavioral issues" as the rationale for the ECT treatment. Although [redacted] testified that the Appellant's behaviors [violence, aggression, bolting-out, etc.] were actually part of the illness and not simply conduct - the Department seized on the behavioral aspect of the Appellant's affliction and compared it with her recent "observed" improvement to conclude that ECT as approved and prescribed here was an unauthorized modification of behavior under policy – and that less restrictive means of treatment were available.

The centerpiece of the Department's case was the testimony of [redacted] who opined that in concert with the [redacted] CMHA CEO she saw ETC treatment as behavior modification. It was prohibited by policy and she saw no evidence of catatonic conduct. *See* Testimony of [redacted].

● The Department argued in the alternative that the Appellant's guardianship was in flux as the family moved from [redacted] County to [redacted] County. When guardianship was established in [redacted] County the Department feared breach of item #1 in the restricted criteria attached to the judge's order. *But see* Department's Exhibit A (B) p. 5 which reads: [ ]

> "Consent to ordinary and emergency medical and surgical treatment. This authority excludes extraordinary procedures including, but not limited to, sterilization, abortion, organ transplants from the ward to another person and experimental treatment."

● The Department also argued that even if ECT were approved their contractor/provider agreement was with [redacted] – not the [redacted].

● The remainder of the Appellant's expansive presentation included hyper-detail on the move from [redacted] County to [redacted] County - including all of services preparation and planning therein. It cannot be fairly said, based on this record that [redacted] CMHA did not know in advance that [redacted] and her [redacted] were coming to [redacted]. *See* Appellant's Exhibits #1, #2, #3 (1-42).

On review, the shear weight of the evidence preponderates in favor of the Appellant on the issue of medical necessity. Every physican, provider and medical professional identified in this

record [with the exception of [redacted]] recommended [continued] ECT for the Appellant as prescribed by [redacted].

WHAT WAS THE LEAST RESTRICTIVE ALTERNATIVE?

The Department witnesses speculated that the diagnosis might now be different and thus lead to a different treatment plan and further, that the risk from lethal catatonia was too great to risk ECT. However, other than observing that the Appellant is in an improved condition the [redacted] CMHA had no such plan.

Surely risk of death - as credibly explained by [redacted] would be sufficient impetus to develop an alternative treatment plan – if one were available. The medical necessity of this service was documented in the IPOS.

Clearly, [redacted], the Department's psychiatrist thought that the plan of [redacted] was the route to follow as did [redacted] CMHA psychologist, [redacted]. *See* Appellant's Exhibit #3 (19) and (20).

Dually afflicted with Catatonia and NMS the Appellant is in a rare but documented class of patient who can benefit from the application of ECT beyond the generally referenced 3 or 4 sessions administered during an emergency. Furthermore, the evidence preponderates and this record supports the idea that there was no other treatment option for the Appellant.

To simply discontinue ECT would risk "rapid deterioration" of the Appellant and a repeat of her prior emergent battle for survival. It is important to remember that in the not too distant past the Appellant was near death because her affliction could not be identified or effectively treated.[6] *See* Testimony of [redacted].

Because the evidence supported the broader idea of medical necessity for ECT – I find for the Appellant based on this record.[7]

As for cost–effectiveness the [redacted] CMHA representative argued that their contract for the provision of ECT is through [redacted] [redacted][8] – not the [redacted]. A fair point - in time the location of the service will likely change because the critical element in the provision of a Medicaid covered service - is the service – and not its location. For now, however, the evidence preponderates that it is medically necessary to treat the Appellant through the office of [redacted] at the [redacted] - most likely until the family is stabilized with all approved services in place at home in [redacted] Michigan.

After review of the Appellant's letters of guardianship – I find no reason for denial of ECT. First, ECT is not referenced as a prohibited procedure. A generally accepted medical

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[6] *See* procedural safeguards throughout MCL 330.1717.
[7] See §2.1, MPM, [Program Requirements] Mental Health/Substance Abuse, at page 8, Oct. 1, 2010.
[8] Presumably, [redacted] is cost effective because of the existing contractual relationship with [redacted] CMHA and closer proximity – although no evidence was submitted on either point.

procedure, ECT is a long-standing medical tool with a misrepresentation in public media.[9] More commonly used to treat depression or schizophrenia as either an emergent or maintenance tool it is generally acknowledged by those familiar with ECT as the only option for a small class of patients [such as the Appellant] "…due to its efficacy."

With ECT subject to titration and close weekly monitoring the testimony and the evidence preponderates in favor of continued ECT treatment for the Appellant. While no procedure is risk free, [redacted] testimony and her published articles [cited by both parties] underscores its practical application and efficacy in this case. This is a serious medical issue to be certain, but it is not an "extraordinary" or "experimental" procedure. *See* Testimony of [redacted], Appellant's Exhibit #3 (39) and Department's Exhibit Sub (K).

Nowhere in the Medicaid Provider Manual or the internal Northwest ECT policy is the issue of [redacted] County residency addressed as a disqualification for medically necessary services. Yet the Department argued that financial responsibility was not clear and might yet rest with [redacted] County. Citizens have a right to travel and move their residency from one county to another. Benefits follow the beneficiary – a fundamental concept recognized in the [redacted]CMHA contract with the Michigan Department of Community Health.[10]

As for the policy advanced by the [redacted]CMHA as supporting denial [suspension] of services there was no evidence that the policy was not followed – even [redacted] said that during her review, "…we did not deny the service – we just did not authorize the payment."

The distilled argument brought by the [redacted]CMHA was that on [redacted], they concluded that [redacted] [via ECT] was attempting to control the Appellant's behavior – an impermissible end under policy. I found that to be an unsupportable argument.

The reality is that [redacted], the Appellant's guardian/[redacted]/advocate was a difficult consumer. He is insistent, officious, often loud [the ALJ had to caution him several times on the record to lower his voice] and I believe the proofs show he was difficult to deal with as a consumer. However disagreeable that experience might have been for employees of the [redacted]CMHA the litany of facts and the time-line presented by [redacted] show that he alerted them early and often on the pending move from [redacted] County [as early as [redacted]] and that he responded in exacting detail to requests from the Department for information.

The [redacted]CMHA is reminded that its contract with the Michigan Department of Community Health [through the Medicaid Provider Manual] requires them to assist beneficiaries. Some consumers require greater effort. *See* Contract, Sections 2.0 and 3.1 and Attachment 3.1.1, Section III(a) Access Standards.

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[9] *One Flew Over the Cuckoo's Nest*, [et al] Casey, 1962; The History of Shock Therapy in Psychiatry, Sabbatini, PhD, www.cerebromente.org Feb 18, 2011

[10] Contract: Part II, §1.3: …Services shall not be delayed or denied as a result of a dispute of payment responsibility between two or more PIHPs…" at p. 25

[11] Records, billings, reports, copies, etc.

Having satisfied their own local agreement (Exhibit J) and after applying the common sense interpretation reached by [redacted] CMHA psychiatrist [redacted] - the critical decision making process should then have been directed at achieving or continuing the best treatment path for the beneficiary. MPM §1.6 Beneficiary Eligibility, *Supra*. The Appellant has preponderated her burden of proof to establish medical necessity for ECT.

The Department improperly suspended Electro-Convulsive Therapy treatment for the Appellant.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly suspended ECT treatment for the Appellant.

IT IS THEREFORE ORDERED that

The Department's decision is REVERSED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/22/2011

***** 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 and 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.