STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-29582 CMH
Case No. [redacted]

Appellant
_____/

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]. [redacted], attorney, appeared on behalf of the Appellant. Her witness was the Appellant's father and guardian, [redacted], attorney, represented the Department. Her witness was [redacted] Area Manager for Clinical Service Innovation. Also in attendance, but not testifying, was [redacted] LPN/aunt.

ISSUE

Did the Community Mental Health Authority properly deny the Appellant's request for out-of-state residential treatment services – specifically placement at [redacted] residential treatment program located in [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 an [redacted] year-old Medicaid beneficiary. (Appellant's Exhibit #1, page 11)

2. When not in-patient (IP) at [redacted] the Appellant lives with her adoptive father and [redacted]-year-old adoptive brother. The adoptive parents are separated with the adoptive mother living in [redacted] with another [redacted]-year-old adoptive child - in order to get respite from the Appellant. (Department's Exhibit B, sub A, pages 6 and 7)

3. The Appellant's biological mother has a history of schizoaffective disorder/Bipolar. She is reported to have consumed alcohol and drugs while pregnant with the Appellant. The biological father has a history of

schizophrenia. (Appellant's Exhibit #2, sub B, page 9 of 13; Department's Exhibit A, page 1 and sub D, page 20)

4. The Appellant has a history of behavioral problems at school – she has been home-schooled since the beginning of [redacted]. (Department's Exhibit A, sub D, page 20)

5. The Appellant is presently IP at [redacted] where she is awaiting discharge. (Department's Exhibit A, sub E, pages 25-55; Department's Exhibit B, sub F, page 65 and sub K page 151)

6. The Appellant came to [redacted] for emergency psychiatric hospitalization via ambulance from [redacted] Emergency Room after she stabbed her "caretaker" with a butter knife. She was admitted to [redacted] with a diagnosis of Mood Disorder, NOS, rule out Bipolar Disorder, NOS and Fetal Alcohol Syndrome. (Department's Exhibit B, sub A, pages 6-10)

7. While at [redacted] the Appellant's guardian adoptive father advocated for his daughter's discharge to [redacted] residential treatment program in [redacted] on the recommendation of the families' private Neuropsychologist, [redacted] who, on or about [redacted][1] diagnosed the Appellant with Dementia/Organic Brain Syndrome Due to Specific Conditions (Generalized, Diffuse Organic Brain Syndrome/Static Encephalopathy Related to Fetal Alcohol Spectrum Disorder [and other maladies], learning disorders and conditions secondary to FASD). (*See* Appellant's Exhibit #1, pages 31, 32)

8. According to assertions in the Appellant's petition for hearing [drafted by the Appellant's former attorney] the Appellant is presently "languishing at [redacted]" even though evidence from that institution demonstrates an improved baseline condition with the Appellant awaiting discharge to a less restrictive environment pending completion of discharge planning - and now this appeal. (*See* Department's Exhibit B – throughout)

9. The Appellant's father does not believe his adoptive daughter is ready for a less restrictive environment. (Department's Exhibit A, sub E, page 42)

10. The Appellant's father has not permitted the CMH to have access to either the Appellant for assessment or medical records from the Appellant's private psychologist. (Department's Exhibit A, sub E, pages 34, 38, 40)

[1] At the time of hearing the Appellant was late for reevaluation on [redacted] own recommendation. Appellant's Exhibit #1, page 37.

11. The Appellant, through her guardian, seeks out-of-state residential placement on [redacted], which was denied by the CMH because the requested services could be provided in Michigan. (Department's Exhibit A, sub B, page 7 and Appellant's Exhibit #1, page 1)

12. Discharge planning, from [redacted], was frustrated when the Appellant's guardian insisted on excluding the CMH from participation in evaluating the Appellant for post IP aftercare while strenuously advocating for out-of-state, residential placement at [redacted].[2] (Department's Exhibit B – throughout)

13. Absent consent the CMH searched the public domain for information concerning the treatment philosophy and potential treatment regiments offered at [redacted]. In addition to a basic difference in approach [individual versus environmental] the providers at [redacted] endorse "restraint" and describe different levels of physical interventions up to and including "containment holds." (*See* Department's Exhibit B, sub H, page 71 and sub J, pages 96-99)

14. It is the position of the CMH that the utilization of restraint and seclusion is not permitted under the Medicaid Provider Manual[3] in reference to [redacted] technique description found in the public domain by the Department. (See Department's Exhibit B, sub J, pages 94-99)

15. Under any aftercare ideas presently envisioned by mental health providers at [redacted] or the CMH, the Appellant would require around the clock care and 2:1 staffing. (Department's Exhibit A, sub E, pages 25-54)

16. There is no dispute that the CMH is providing funding for IP mental health services at [redacted]. (Department's Exhibit A, sub E, page 30)

17. The CMH maintains that they have been denied access to the necessary assessment tools [by the Appellant's father] thus frustrating their ability to develop a post hospitalization treatment plan. Accordingly, out-of-state residential placement was denied because, in fact, such IP placement exists in the State of Michigan. (*See* Department's Exhibit B, sub K, pages 138-150; and a letter from [redacted] to [redacted] concerning ideas for aftercare at page 151)

[2] Unfortunately, the guardian's obstinence also extended to failure to execute Release of Information and Consent and Acknowledgements; demands to audio record doctor-family status meetings, [thus frustrating completion of [redacted] Needs Assessment for future treatment]. He had general disagreement with any aftercare planning that didn't involve [redacted]. Department's Exhibit A, progress notes, pp. 25-54.

[3] MPM, §3.3 Behavior Treatment Review, Mental Health [ ], January 1, 2012, page 16.

18. On [redacted], the Appellant was advised of her further appeal rights. (Department's Exhibit A, page 7)

19. The instant appeal was received by the Michigan Administrative Hearing System for the Department of Community Health 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

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…

Section 1915(c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided

> pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

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 and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The Macomb County Community Mental Health Authority (CMH) contracts with the Michigan Department of Community Health to provide those services.

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*.*

The MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1 and Attachment 3.1.1, Section III(a) Access Standards-10/1/08, page 4*,* directs a CMH to the Department's Medicaid Provider Manual (MPM) for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's MPM Mental Health Chapter delineates the prohibition against restraint [and seclusion] as consistent with federal regulations and sets forth the requirement for MDCH prior review of any proposed behavior treatment plan where hands-on care "aversive, restrictive or intrusive techniques" is contemplated.[4]

The MPM further proscribes services to children with Serious Emotional Disturbance (SED) in Child Care Institutions (CCI) - unless for the purpose of transitioning out the institution. Michigan Medicaid does cover services to children with developmental disability (DD) in a CCI - exclusively serving the DD population and with an enforced policy prohibiting restraint and seclusion.[5] Moreover, the MPM restricts treatment from beyond borderland providers to those prior authorized by the MDCH for [non-emergency] services not available in Michigan and its borderland states – obviously Oregon is not a borderland state.[6]

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[4] MPM, Mental Health [ ], §3.3, *Supra,* at page 16.
[5] MPM, Mental Health [ ], §2.3 Location of Service, January 1, 2012, pages 9, 10.
[6] MPM, General Information for Providers, §7.3 Out of State/Beyond Borderland Providers.

The Testimony

The Department witness explained that the Appellant's request was denied for lack of prior authorization by the Department and the out-of-state treatment prohibition, but also because there was no agreement in the available documentation that the Appellant's chief mental health issue is FASD. She reiterated the CMH's lack of access to records owing to the father's failure to authorize release.

Witness [redacted] added that there was additional concern about the risk inherent in follow-up care owing to the guardian's exisiting refusal to cooperate with the Department. Finally, she said that the approach to treatment should emphasize the individual – and not the condition. This was a concern presaged by CMH Clinical Director, [redacted] who wrote, while answering one of the guardian's inquiries to MDCH Director [redacted]:

> The most effective mental health treatment focuses on persons, not conditions…. [He added that] the Appellant has been assessed and/or served by multiple mental health professionals in the last two years. Multiple conditions have been identified. There is no clear consensus that FASD is the most prominent condition or the most important factor in the selection of further treatment interventions. Clarity about what needs to treated, and in what order and amount, is a prerequisite for selection of the most efficacious treatment provider.
>
> *See* Department's Exhibit A and B – throughout.

[redacted] also credited the Appellant's father for interposing delay in the follow-up care decision owing to his repeated refusals to sign releases so that the CMH could clarify what follow–up care would be most appropriate. He added that multiple Michigan-based organizations provide person centered mental health treatment for children afflicted with FAS[D] - including many organizations providing treatment at a less restrictive level of care. *See* Department's Exhibit B, sub H, at pages 71, 72.

[redacted] then added that long term residential placement is generally not available for those afflicted with SED, while those identified as DD might receive such services – depending on the exclusivity of the institution. [redacted] stated that based on review of the [redacted] documents [found in the public domain] it appeared as though the mental health providers there used or endorsed the prohibited practices of seclusion and restraint in their "environmentally" oriented program.

[redacted] testified that in-state placement is generally preferable owing to the proximity of family and to foster seamless reintegration into the community at large. She referenced the letter from [redacted] that the Appellant was ready for discharge to other than IP

residential setting by recommending a community based plan – albeit highly structured and staffed with monthly psychiatrist contact for the Appellant.

On cross examination [redacted] admitted that [redacted] did not rule out [redacted] anywhere in his one page letter.[7]

Review of Facts and Law

The Appellant's petition fails on three (3) levels:

First, it is simply not supportable under either the mental health code or the MPM – based on the record presented at hearing. *Supra.*

Second, the Appellant's guardian cannot use the law as both a shield and a sword. The evidence clearly demonstrated that the Appellant's guardian was zealous in blocking access of the CMH to participate in discharge planning for the Appellant – whose medical professionals at [redacted] believe is ready for discharge. [redacted] has also stated that it just "doesn't matter"[8] where the service is provided. *See* Department's Exhibit A, sub E, at pages 25-55.

Finally, even the Appellant's proofs cast doubt on the true motives of the guardian, citing with approval:

> "It is unknown if the current living situation, with her mother in [redacted], will have a detrimental effect on [redacted]. Her mother and father have been so stressed out with her behavior that they are considering giving her back to the state and relinquishing parenthood. They feel they are not prepared for the life that having a child with FASD is presenting to them. They feel they that they have tried everything and are not receiving adequate supports from the county, the school or the medical community. They are also considering placing [redacted] in a camp in [redacted], but do not have the funds to afford it."
>
> *See* Appellant's Exhibit 2, sub B, page 5 of 13.

Unfortunately the evidence also shows that the parents have hamstrung the county [CMH] by denying access to the Appellant or her medical records, they have disagreed with the Appellant's IEP prepared by the school system – taking her out of school and engaging in presently unsuccessful home schooling and lastly they have anchored the Appellant's medical position on a [redacted]-year old evaluation by their private psychologist, [redacted]

[7] *See* Appellant's Exhibit #1.
[8] Department's Exhibit A, sub E, page 43.

It is an axiomatic principle that Medicaid attaches for the benefit of the categorically needy recipients like the Appellant - not well intended others. 42 CFR.200 *et seq* [Subpart B].

Furthermore, Michigan law requires that a mental health services recipient receive services in the least restrictive setting. The Michigan Mental Health Code at MCL 330.1708, states:

> **[Standard for mental health services]**
>
> (1) A recipient shall receive mental health services suited to his or her condition.
>
> (2) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.
>
> (3) Mental health services shall be offered in the least restrictive setting that is appropriate and available.
>
> (4) A recipient has the right to be treated with dignity and respect. (Emphasis supplied)
>
> ***

Denied access to medical records the CMH searched the public domain for information about [redacted] and properly concluded, based on the information available to them, that the institution utilizes a form of restraint and seclusion prohibited under Michigan law. *See* Department's Exhibit B, sub J, at pages 94, 96, 97 and 109.

This information alone would be adequate reason to deny out-of-state, IP treatment for the Appellant. If there was a more benevolent practice at [redacted] – the time to have shared that information was well before hearing.[9]

Furthermore, [redacted], in its public domain, advertises a family orientation in its treatment efforts:

> **How Are Families Involved?**
>
> We form a partnership with families who define the goals of treatment. Families are encouraged to play an active role in all aspects of treatment and are asked to contact and visit their child often. For families who live out of our area, video conferencing is available and an on-site apartment is

[9] *See* MCL 330.1708; 330.1740; 330.1742; Mich Admin Code R 330.7199(2)(g); 42 CFR 438.100 *et seq* and the Medicaid Provider Manual (MPM) Mental Health [ ] chapter, generally.

> provided at no cost, so families can stay on the property for visits.
>
> [Department's Exhibit B, page 31]

The selection of [redacted] would place the Appellant's family, as of the date of hearing, in three (3) different states: [redacted] and [redacted]. There was no evidence in this record of family reconsolidation at any point in the near future.

The contractual requirement under which the CMH [or any other PIHP] receives funding prohibits the utilization of seclusion and restraint techniques as physical management – even if consented to by the Appellant and/or the guardian.[10]

Under contract the Michigan Department of Community Health flatly prohibits its mental health agencies from participating in violence perpetrated on recipients of mental health services in the name of treatment – when other viable and gradual protocols exist.

Under Michigan law physical management as an element of a plan of care is prohibited:

> ● "Physical management" means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others. [R330.7001(m)]
>
> Rule 330.7243(11) states: Physical management as defined in R330.7001(m) may only be used in situations when a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of serious or non-serious physical harm.
>
> Both of the following shall apply:
>
> (i) Physical management shall not be included as a component in a behavior treatment plan.
> (ii) Prone immobilization of a recipient for the purpose of behavior control is prohibited unless implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient's record.

At the [redacted] public domain - information concerning containment holds and precursors of hands-on "firm and friendly" physical interventions are clearly endorsed.

[10] *See* MPM, Mental Health [ ] §3.3 *Supra*, at page 16.

However well intended these "environmentally" based providers might be, the CMH acts lawfully by discarding such measures as described in the public domain and by reminding the Appellant that the [redacted] based providers would be subject to Michigan law - even if the out-of-state residential placement were to be later permitted.[11]

The MPM further requires the CMH to exhaust its remedies prior to approval of IP treatment measures for children:

> 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.
>
> **[ ] PIHP DECISIONS**
>
> Using criteria for medical necessity, a PIHP may:
>
> - Deny services that are:

[11] MDCH Mental Health [ ], Technical Requirement for Behavior Treatment Plan Review Committees, *Contract attachment* P.1.4.1. 10/1/08 states in part: … MDCH will not tolerate violence perpetrated on the recipients of public mental health services in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop a individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future [R330.7199(2)(g)] …

- 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, §2.5.C, Supports, Services and Treatment
Authorized by the PHIP, Mental Health [ ],
January 1, 2012, at page 13[12] and §2.5.D at page 14

[ ] 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

[12] This version of the MPM at section 2.5 *et seq* is identical to the edition in place at the time of the Department's denial of service.

of community inclusion and participation, independence, recovery, or productivity.

[ ] 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. (Emphasis supplied)

MPM, *Supra* §§2.5.A and 2.5.B, pages 12, 13.

Based on current law and Medicaid policy it would therefore not be permissible to use seclusion or physical management in a yet to be developed care plan solely because the technique espoused by its advocate is alleged to be more successful in controlling behavior than other permissible techniques.

Conclusion

At hearing the ALJ allowed the Appellant's guardian to make a statement[13] – to be appended to the Appellant's written closing. It is restated here to demonstrate the fundamental problem with providing efficacious, appropriate and the least restrictive services for the Appellant.

> **MCCMH TRIBUNAL,** [redacted]
>
> Your Honor, May I make a closing statement? (Judge allowed me to proceed)
>
> The parents of [redacted] have always provided [redacted] with what is in her best interest and safety. We have presented to CMH **factual documentation, an** evaluation from a world renowned expert, Neuropsychologist, [redacted] has recommended that [redacted] attend an out of the state facility due to the severity of her brain damage caused by alcohol and other drugs while in the womb of her biological mother. [redacted] was born with multiple deficits which include, FASD, Organic Mood Disorder, Developmental Dylexia, and severe Sensory disorders. [redacted] was diagnosed with Fetal Alcohol Spectrum Disorder from the [redacted] FASD Clinic in [redacted].
>
> The out of state residential facility has accepted [redacted] based upon [redacted] Evaluation. This facility provides the Appropriate Level of Care to meet our daughter's individualized needs, thus providing [redacted] the opportunity for a better outcome in her life. In addition, in my opinion, we have provided documentation showing that this out of state residential facility is a cost effective solution for Medicaid funds. Some more good news – children typically require LESS Medication upon leaving this treatment program.
>
> Documentation has been provided to CMH listing other states that have released Medicaid funds to allow children to attend this treatment program. I support that our daughter's individualized complex and challenging physical needs can be addressed at this out of state facility recommended by Dr. [redacted], and supported by [redacted]s pediatrician, Dr. [redacted].

[13] Without objection the Appellant's guardian was allowed to read his closing statement into the record, it was attached to counsel's closing statement as ordered by the ALJ.

I understand there are individuals in this room who would prefer to keep Medicaid Monies in Michigan. My family has been and continues to be placed in a vulnerable situation subject to a fight by those who are unfamiliar with the seriousness and complexity of our daughter's FASD disability.

Please do what is RIGHT for [redacted] NEEDS, sign the necessary paperwork to fund the treatment plan at [redacted].

As [redacted] adopted parents this is all we ask because we love [redacted]. We continue to be responsible parents, and want to hold others responsible for what is in [redacted]s Best Interest, giving her an opportunity to improve, keeping [redacted] safe, as well as family members and the community safe.

I ask each one of you in this room; **IF YOUR DOCTOR RECOMMENDED YOU SEE A SPECIALIST FOR WHAT WAS PHYSICALLY WRONG WITH YOU, WOULD YOU NOT COMPLY IN FULL WITH THE RECOMMENDATION FROM THAT SPECIALIST THAT COULD IMPROVE YOUR CONDITION?**

Please take to heart what I have said to you in my closing statement.

Thank you for listening as I advocate for my daughter's special needs.

Cordially,

[redacted]

***

As the Department's evidence showed the main impediment to the Appellant's further care was not the mental health providers at [redacted] or [redacted], or expelled Case Manager [redacted], – it was the Appellant's guardian, her adoptive father, [redacted].

For reasons known only to [redacted], he has taken a position [as described in his closing] which seeks to obviate discharge planning by qualified mental health professionals in Michigan while seeking out-of-state residential placement based on a

diagnosis not universally shared [in this record] by the many mental health providers involved in the Appellant's care - and then he seeks payment for these services from the very mental health providers he excludes [CMH] from his daughter's aftercare.

If the only acceptable solution [out-of-state IP residential treatment] is the fundamental position of the Appellant and it has a supportable basis, then this thesis should withstand the minimally intrusive test of examination of the Appellant and her medical record by the qualified mental health professionals of the CMH – otherwise the only conclusion to be drawn based on this record is that the parent's are imposing tactics for the purpose of disguising their buyer's remorse in having adopted a child – now difficult to manage – with special needs.

[redacted] recommendations, while learned, are likely not the only avenue of treatment presently available to the Appellant. Furthermore, his diagnosis would need to be viewed in light of the Appellant's progress at [redacted] to present and should be tested by the mental health professionals of the CMH.

As the evidence preponderates today and as [redacted] said earlier: "There is no clear consensus that FASD is the most prominent condition or the most important factor in the selection of further treatment interventions. Clarity about what needs to be treated, and in what order and amount, is a pre-requisite for selection of the most efficacious treatment provider."

The Appellant has failed to preponderate her burden of proof.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied out-of-state residential treatment services as the requested service can be provided in Michigan.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

_____

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

[redacted]
Docket No. 2011-29582 CMH
Decision and Order

cc: [redacted]

Date Mailed: 1/30/2012

***** NOTICE *****

The Michigan Administrative Hearing System 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.