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) 373-4147

IN THE MATTER OF:

Docket No. 2014-868 CMH

Appellant
______________________/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon a request for a hearing filed by Appellant.

After due notice, a hearing was held on Appellant appeared and testified on her own behalf. , Fair Hearings Officer, appeared and testified on behalf of Respondent

ISSUE

Did properly terminate Appellant's medication review 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. Appellant is a year-old Medicaid beneficiary who has been diagnosed with Mood Disorder, NOS; cannabis abuse; and Attention-Deficit/Hyperactivity Disorder, NOS. (Respondent's Exhibit 1, pages 1-2).

2. Appellant is a member of the population required to enroll in a Medicaid Managed Health Plan (MHP) and she has a primary care physician through her MHP. (Testimony of Appellant; Testimony of).

3. Appellant has also been receiving outpatient therapy and medication review services through (Testimony of Appellant; Testimony of

4. Berrien is under contract with the Michigan Department of Community Health (MDCH) to provide specified Medicaid covered services to people who reside in its service area and met the criteria for services.

5. Outpatient therapy and medication review were the only services Appellant was receiving through (Testimony of Appellant; Testimony of

6. Appellant last attended outpatient therapy on . She then missed her next appointment and her therapist was unable to contact her. (Respondent's Exhibit A, pages 1-5).

7. On sent Appellant written notice that her therapy services would be terminated on . The notice also informed Appellant of her right to request a hearing if she disagreed with the termination. (Respondent's Exhibit A, pages 6-7).

8. On staff, including a , conducted a review of Appellant's medication review and determined that it should also be terminated because it was no longer medically necessary as Appellant, who has a diagnosis of cannabis abuse, had not attended outpatient therapy since and was getting stimulant medications through both her primary care physician and her therapist. (Respondent's Exhibit A, pages 10-15; Testimony of

9. Also, on sent Appellant written notice that her medication review services would be terminated on . That second notice also informed Appellant of her right to request a hearing. (Respondent's Exhibit A, pages 8-9).

10. On , the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, page 1).

11. While that request for hearing indicated that Appellant was appealing both terminations, Appellant testified during the hearing that she is no longer interested in outpatient therapy and is only appealing the termination of medication review services. (Testimony of Appellant).

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 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

Moreover, 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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

contracts with MDCH to provide services under the waiver pursuant to its contract obligations with the Department, but eligibility for those services is still set by Department policy.

With respect to eligibility, the MPM states:

1.6 BENEFICIARY ELIGIBILITY

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:

- The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.

- The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing

routine medication management without further specialized services and supports.

In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:

- The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).

- The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.

- The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors

> from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.
>
> * * *
>
> Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 3-4

When beneficiaries are eligible, medication review is among the services that [redacted] can provide. With respect to medication review, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **3.16 MEDICATION REVIEW**
>
> Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication
>
> review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

MPM, July 1, 2013 version
Mental Health/Substance Abuse Chapter
pages 18-19

However, while medication review is a Medicaid-covered service, Medicaid beneficiaries are still only entitled to medically necessary covered services for which they are eligible and services must also be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See* 42 CFR 440.230.

With respect to medical necessity, the MPM, July 1, 2013 version, Mental Health/Substance Abuse Chapter, pages 12-13, 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.

Here, [redacted] terminated Appellant's medication review, which is the sole service she wants through [redacted], after finding that the service was no longer medically necessary. In particular, [redacted] noted that Appellant, who has a diagnosis of cannabis abuse, had not attended outpatient therapy since [redacted] and was getting stimulant medications through both her primary care physician at her MHP and her therapist at [redacted] (Respondent's Exhibit A, pages 10-15; Testimony of [redacted])

Appellant has appealed that termination and, in doing so, bears the burden of proving by a preponderance of the evidence that erred. For the reasons discussed below, this Administrative Law Judge finds that Appellant has not met that burden of proof.

Appellant has a primary care physician through her MHP and it is undisputed in this case that both that physician and Appellant's therapist through have been prescribing stimulant medications. appears to suspect that Appellant is engaging in improper behavior, but its witness could not elaborate on its position beyond noting that Appellant is receiving such medications from multiple sources while Appellant also credibly testified that the stimulants were prescribed for different conditions and reasons.

Nevertheless, given the very limited services Appellant seeks, this Administrative Law Judge finds that Appellant has failed to demonstrate that medication review services through are still medically necessary or that her mental health needs exceed the benefits provided by her MHP. Appellant herself believes that she no longer needs outpatient therapy and, while she does still want medication reviews, she can continue to receive that limited service through her MHP and it is not necessary for to provide it as well.

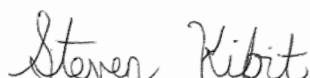
Accordingly, Appellant has failed to meet his burden of demonstrating that medication review is still medically necessary and decision to terminate the service should be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that properly terminated Appellant's medication management services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.



Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: 1

Date Mailed:

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***** 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 Michigan Administrative Hearing System 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.