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:

[redacted],

Docket No. 14-017864 SAS
Case No. [redacted]

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*., upon Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared on her own behalf. [redacted], Fair Hearing Officer, appeared and testified on behalf of the Respondent, Community Mental Health Authority of [redacted] and [redacted] counties (CMHA-[redacted] or Department). [redacted], Utilization Reviewer, appeared as a witness for the CMH.

ISSUE

Did CMHA[redacted] properly deny Appellant's request for outpatient methadone treatment?

FINDINGS OF FACT

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

1. CMHA-[redacted] is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the its service area.

2. Appellant is a [redacted] year-old Medicaid beneficiary, born [redacted], who has used heroin on and off for the past [redacted] years. (Exhibit A, pp 61, 72; Testimony)

3. In [redacted], Appellant contacted CMHA-[redacted] and requested outpatient methadone treatment (OMT). (Exhibit A, p 32; Testimony).

4. Following that request, CMHA-[redacted] referred Appellant for a substance

abuse evaluation, which was conducted on [redacted]. (Exhibit A, pp 61-75)

5. Following the evaluation, the evaluator recommended that Appellant receive OMT, along with individual therapy, group therapy and care management services. (Exhibit A, p 72)

6. However, after reviewing the evaluation and Appellant's past clinical records, CMHA-[redacted] denied Appellant's request for OMT and offered Appellant medically managed detoxification followed by an inpatient residential treatment program. CMHA-[redacted] determined that OMT was not the most appropriate treatment for Appellant because Appellant was seeking methadone for pain management, not for substance abuse treatment. (Exhibit A, p 32; Testimony)

7. Appellant's request for hearing was received by the Michigan Administrative Hearing System on [redacted]. (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 statute, the Social Welfare Act (MCL 400.1 *et seq*.), various portions of Michigan's Administrative Code (1979 AC, R 400.1101 *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 (other than subsection(s) 1902(a)(15), 1902(bb), and 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 for Medicare and Medicaid Services (CMS), the 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 the MDCH to provide services under this 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. Specific service and support definitions included under and associated with state plan responsibilities are set forth in the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual (MPM).

Among the services that CMHA-[redacted] can authorize are substance abuse services, such as outpatient methadone assistance, and, with respect to such services, the applicable version of the MPM states:

> **SECTION 12 – SUBSTANCE ABUSE SERVICES**
>
> **12.1 COVERED SERVICES - OUTPATIENT CARE [CHANGE MADE 10/1/14]**
>
> 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 that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. 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) Criteria. **(revised 10/1/14)** Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.

12.1.A. ELIGIBILITY [CHANGE MADE 10/1/14]

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.
- The American Society of Addiction Medicine (ASAM) Criteria **(revised 10/1/14)** 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 Criteria **(revised 10/1/14)**:
  - 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.

12.1.B. 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:

* * *

Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT) Approved Pharmacological Supports

Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection.

* * *

12.2 TREATMENT (DPT/CSAT) APPROVED PHARMACOLOGICAL SUPPORTS

12.2.A. PROVISION OF SERVICES

- Opiate-dependent beneficiaries may be provided chemotherapy using methadone as an adjunct to a treatment service. 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;

  - certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT);

- licensed by the Drug Enforcement Administration (DEA); and

- accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF)).

- Methadone must be administered by an appropriately-licensed MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

12.2.B. COVERED SERVICES

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

- Methadone medication
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests (including health screening tests as part of the initial physical exam, pregnancy test at admission, and required toxicology tests)
- TB skin test (as ordered by physician)

12.2.C. ELIGIBILITY CRITERIA [CHANGE MADE 10/1/14]

Medical necessity requirements shall be used to determine the need for methadone as an adjunct treatment and recovery service.

All six dimensions of the American Society of Addiction Medicine (ASAM) criteria **(revised 10/1/14)** must be addressed:

- Acute intoxication and/or withdrawal potential.
- Biomedical conditions and complications.

- Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).

- Treatment acceptance/resistance.

- Relapse/continued use potential.

- Recovery/living environment

12.2.D. ADMISSION CRITERIA [CHANGE MADE 10/1/14]

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Criteria, **(revised 10/1/14)** and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification

- Sub-acute Detoxification

- Residential Care

- Buprenorphine/Naloxone

- Non-Medication Assisted Outpatient Treatment

* * *

12.2.E. MEDICAL MAINTENANCE PHASE

When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance

(methadone only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant non-stabilized co-occurring disorders.

* * *

12.4 RESIDENTIAL TREATMENT [SUBSECTION ADDED 7/1/14; CHANGE MADE 10/1/14]

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a Substance Abuse Treatment Specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.

- Admissions to Residential Treatment must be based on:

  - Medical necessity criteria

  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria **(revised 10/1/14)**

- The PIHP may authorize up to 22 days of treatment.

- Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to less intensive treatment. **(text added/re-located 7/1/14)**

* * *

12.5 EXCLUDED SERVICES [RE-NUMBERED 7/1/14; CHANGE MADE 10/1/14]

- 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. [*Medicaid Provider Manual, Mental Health/Substance Abuse*, October 1, 2014, pp. 70-81, emphasis added].

However, as discussed in the above policy, while outpatient methadone treatment is a Medicaid covered services, Medicaid beneficiaries are still only entitled to medically necessary covered services for which they are eligible and 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. Regarding medical necessity, the applicable version of the MPM states:

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; 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.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; 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.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

Deny Services:

- that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- that are experimental or investigational in nature; or
- that are 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. [*Medicaid Provider Manual*, *Mental Health/Substance Abuse*, October 1, 2014, pp. 12-14].

Here, Appellant requested outpatient methadone treatment through CMHA-[redacted], but her request was denied and CMHA-[redacted] instead offered a medically managed detoxification followed by an inpatient residential treatment program. Appellant then refused the offered services.

CMHA[redacted] Utilization Reviewer testified that after reviewing Appellant's clinical information, her request for OMT was denied because it was not the most appropriate level of care. CMHA[redacted] Utilization Reviewer indicated that Appellant's primary concern in requesting OMT was for pain management, not substance abuse treatment, and that OMT is not approved for use through Medicaid for pain management. In

support of this conclusion, CMHA-[redacted] Utilization Reviewer pointed to notes from her phone call with Appellant on [redacted], Appellant's own request for hearing, and the assessment completed on [redacted], where Appellant indicated repeatedly that she was seeking OMT for pain management. (Exhibit A, pp 32, 56-57, 61).

CMHA-[redacted] Utilization Reviewer testified that Appellant's request for OMT was also denied because Appellant has had previous, unsuccessful attempts with OMT, and was discharged from her last OMT program for violating rules. CMHA-[redacted] Utilization Reviewer indicated that records indicated that Appellant had repeated positive drug screens for opiates during past OMT sessions and had missed counseling and therapy appointments. (Exhibit A, pp 33, 42-52). CMHA-[redacted] Utilization Reviewer pointed out that it is very dangerous to mix opiates and methadone as it seriously increases the risk for drug overdose.

CMHA-[redacted] Utilization Reviewer also testified that criteria from the Medicaid Provider Manual indicates that OMT is only appropriate for persons with "minimal or manageable medical conditions" and that Appellant's medical conditions were more serious than that. CMHA[redacted] Utilization Reviewer testified that based on all of the evidence, it was determined that detoxification would be the most appropriate level of care for Appellant.

Appellant testified that she has since returned to the methadone clinic and is paying cash for OMT at the present time. Appellant indicated that she left her last OMT program on her own, she was not kicked out. Appellant admitted that she is in pain every day and was seeking OMT for pain management. Appellant explained that she has already lost one kidney due to all of the pain medications she has had to take in the past and prefers to use methadone to treat the pain because it has fewer side effects. Appellant testified that she could not go to detoxification because the medications they would give her would probably kill her, given her health conditions. Appellant testified that she has had success with OMT in the past and that she only tested positive for opiates while in OMT on two occasions.

Appellant bears the burden of proving by a preponderance of the evidence that the CMHA-[redacted] erred and that outpatient methadone treatment is a medical necessity in accordance with the Code of Federal Regulations. Given the above evidence and policies, Appellant did not meet that burden of proof. Policy requires that decisions to admit an individual for outpatient methadone treatment must be based on medical necessity criteria and that the determination of what services are medically necessary should be made by appropriately trained substance abuse professionals with sufficient clinical experience. In this case, CMHA-[redacted] decisions were based on the professional judgment of its witnesses that the specific services requested by Appellant would be not successful at this time and are therefore not medically necessary. CMHA-[redacted] properly denied Appellant's request for OMT because Appellant was seeking OMT for pain management, not substance abuse treatment, which is not an approved usage for OMT

under Medicaid. Furthermore, Appellant has been unsuccessful with OMT in the past, at least as it relates to treating her heroin addiction.

Accordingly, given the above evidence and policies, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proving by a preponderance of the evidence that outpatient methadone treatment is medically necessary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMHA-[redacted] properly denied Appellant's request for outpatient methadone treatment.

IT IS THEREFORE ORDERED that:

CMHA-CEI's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

RJM/[redacted]

Date Signed: [redacted]

Date Mailed: [redacted]

cc: [redacted]

***** 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.