STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 15-002524 SAS

[redacted], [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*., and upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted]r, MPA, Fair Hearings Officer, appeared and testified on behalf of the Respondent Community Mental Health Authority of [redacted], and [redacted] counties [redacted] [redacted]s, MA, LLPC, a Utilization Reviewer at [redacted] Care Coordination Center also testified as a witness for Respondent.

ISSUE

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

2. Appellant is a [redacted] year-old Medicaid beneficiary (DOB 1[redacted]. (Exhibit A, p. 44 and testimony).

3. On [redacted] [redacted] Appellant called [redacted]l and requested outpatient methadone treatment (OMT). (Exhibit A, p. 34 and testimony).

4. Following that request, [redacted] I referred Appellant for a substance abuse evaluation at [redacted] However, on [redacted], Appellant advised that she missed the appointment at [redacted] because she was sick. (Exhibit A, p. 32).

5. On [redacted] Appellant presented herself to [redacted] for a substance abuse evaluation for possible OMT. The evaluation was conducted at [redacted] by [redacted] MA, LPC, CAADC. [redacted] diagnosed Appellant with Opioid Dependence, and recommended that she complete methadone treatment; submit to random drug and alcohol testing; and, attend support groups [redacted] times per week. (Exhibit A, pp. 43-52 and testimony).

6. On [redacted], after reviewing the Appellant's clinical documentation along with [redacted] evaluation and the information received from her direct contact with the Appellant, [redacted] a Utilization Reviewer at [redacted] I Care Coordination Center rejected the recommendation for methadone treatment, and advised the Appellant that she would be appropriate for a medically managed detox and residential treatment services. (Exhibit A, p. 1, 36-37 and testimony).

7. On [redacted] sent Appellant a Notice of Action denying authorization for methadone assisted treatment. The reason given for the denial was that it was not medically necessary. The notice advised that the clinical documentation reviewed by the [redacted] Care Coordination Center demonstrated that there is another appropriate, efficacious, less restrictive and cost effective service that would meet the Appellant's needs, i.e., detox and residential treatment services. (Exhibit A, pp. 36-37).

8. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Exhibit A, p. 40).

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-CEI 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**
> 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. 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

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 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:
  - 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

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

All six dimensions of the American Society of Addiction Medicine (ASAM) criteria 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

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, 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

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

- 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.

* * *

12.5 EXCLUDED SERVICES

- Room and board;

- All other services not addressed within Covered or Allowable Services; and

- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

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

- Acute detoxification.
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM).
- Medications used in the treatment/management of addictive disorders.
- Emergency medical care.
- Emergency transportation.
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
- Routine transportation to substance abuse treatment services which is the responsibility of the local DHS. [*Medicaid Provider Manual, Mental Health/Substance Abuse*, January 1, 2015, 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*, January 1, 2015, pp. 12-14].

Here, Appellant requested outpatient methadone treatment through [redacted], but her request was denied and [redacted] instead offered a medically managed detoxification followed by residential treatment services. [redacted] stated that based on the law, the regulations, and the Medicaid policy quoted above [redacted] determined that methadone treatment was not medically necessary for the Appellant. Appellant was offered detoxification and residential treatment services instead of the methadone treatment. Appellant declined the services offered through [redacted].

According to [redacted] witness [redacted], she reviewed the Appellant's clinical documentation including the clinical assessment conducted by [redacted] and the information received through phone contact with the Appellant. [redacted] was responsible for making a recommendation for the most appropriate level of care for the Appellant based on the ASAM criteria. [redacted] pointed to the clinical information that related to the Appellant's motivation for the current treatment which is part of the ASAM criteria for the Appellant's readiness for change. The information showed that the Appellant had been involved in medication assisted treatment in the past and had left those services against the medical advice of the staff. Appellant also had continuing in treatment transfers. (See Exhibit A, p. 33).

[redacted] stated the call logs for the Appellant showed that on [redacted] reported that the Appellant had gone from clinic to clinic which they did not believe was beneficial for her recovery, and they reported the Appellant had problems with their benzo policy, and they were not going to accept her back in their program due to her continued benzo use and her going from clinic to clinic. [redacted] stated she also spoke to the Appellant in person on [redacted] and found out that the Appellant was currently working with her physician to wean off her prescribed medications including Percocet, Loratab, and Xanax. [redacted] stated that the information put the Appellant under Level 1.0 on the ASAM criteria for detoxification and residential treatment. (See Exhibit A, pp. 10-11, 34).

[redacted] noted that a portion of the Appellant's drug screen history showed the Appellant was positive for Barbiturates on [redacted] and positive for cocaine on [redacted] while taking methadone treatments. [redacted] stated that both drugs are contraindicated while undergoing methadone treatment. (See Exhibit A, p. 42). [redacted]. [redacted] noted that the [redacted] assessment also references the pain issues and use of medications that led to the Appellant's relapse on opiate pills. (See Exhibit A, p. 44). The assessment also indicated that the Appellant posed no risk to the community of a communicable disease, or criminality that might indicate the need for methadone treatment under the ASAM criteria. (Exhibit A, pp. 28, 43-52).

[redacted] concluded that methadone treatment was not appropriate for the Appellant because another level of treatment would meet the Appellant's needs more cost effectively, and due to her continued use while undergoing methadone treatment in the past with other providers, it was determined that the Appellant wasn't a good candidate for methadone treatment. Based on the information reviewed by [redacted], she found that detoxification followed by residential treatment services was the most appropriate and least restrictive level of treatment necessary for the Appellant.

In response, Appellant testified that she didn't think [redacted] I had given a full picture of her methadone treatment. Appellant said she had surgery in [redacted] and was put on narcotics at the time and was trying to get off the methadone. She said she

has gone through detox [redacted] times already. Appellant said she went off methadone treatment in [redacted] but realized that was a mistake and that is why she wants to go back on the methadone. Appellant claimed her cocaine use did not occur while she was in treatment and said her drug use was negative other than for her surgeries. Appellant said she doesn't want to die and doesn't want to go through this anymore.

Appellant bears the burden of proving by a preponderance of the evidence that the [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, [redacted] decisions were based on the professional judgment of its witness that the specific services requested by Appellant would not be successful at this time and they are therefore not medically necessary.

The above policy regarding medically necessary services does provide that medically necessary services must be sufficient in amount, scope and duration to reasonably achieve their purpose. Here, the information the witness based her decision on, such as the fact that Appellant requires treatment that would include detoxification followed by residential treatment services, and that her use of other substances including benzodiazepines and cocaine is very dangerous when mixed with methadone, demonstrates that methadone treatment would not be sufficient in amount, scope and duration to reasonably achieve the intended purpose in this case. The clinical information submitted in this case supports [redacted] determination that outpatient methadone treatment would not be reasonably likely to achieve its goals for the Appellant in this case.

Accordingly, given the above evidence and policies, the undersigned Administrative Law Judge finds that the Appellant has failed to meet her burden of proving by a preponderance of the evidence that outpatient methadone treatment is medically necessary in this case and [redacted] decision to only offer other services is affirmed.

DECISION AND ORDER

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

[redacted]
Docket No. 15-002524 SAS
Decision and Order

IT IS THEREFORE ORDERED that:

[redacted] decision is **AFFIRMED**.

William D Bond

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

WDB/db

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.