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. 15-020140 NMRE
Case No. [redacted]

[redacted]

Appellant
_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. Attorney [redacted] appeared on behalf of Appellant. [redacted], Appellant's mother, appeared as a witness

[redacted] CEO, represented Respondent, [redacted] or Department). [redacted], Quality Improvement Substance Use Specialist; [redacted], Substance Use Disorder Services System Coordinator; and [redacted], Intake Specialist, appeared as witnesses for the Department.

ISSUE

Did [redacted] properly deny Appellant's request for Long Term Residential Substance Use Disorder 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 [redacted] year old Medicaid beneficiary, born [redacted], who has been receiving services through [redacted] (Exhibit A; Exhibit 2, p 9; Testimony)

2. [redacted] is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the [redacted] service area. (Exhibit A; Testimony)

3. Appellant is diagnosed with Autism Spectrum Disorder, mild to moderate, ADHD-combined type, Substance Use Disorder, and Major Depression with anxiety features. (Exhibit 2, p 33; Testimony).

4. In [redacted], Appellant was placed at [redacted] for inpatient residential substance abuse and mental health treatment. Upon release from [redacted], Appellant followed up with outpatient treatment. (Exhibits A, 1-9; Testimony)

5. In [redacted], Appellant's mother again sought inpatient residential treatment for Appellant. (Exhibits A, 1-9; Testimony)

6. Following a telephone screening, Appellant was approved for intensive outpatient treatment, but was denied inpatient residential treatment. [redacted] based its decision on information provided by Appellant and his mother. In making its decision, [redacted] used criteria from the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC), as required by the Medicaid Provider Manual. When Appellant's mother disagreed with the results of the telephone screening, [redacted] agreed to have Appellant come in for a full, in-person assessment. (Exhibit A, pp 4-9; Testimony)

7. However, before the assessment could be completed, Appellant was placed in a secure juvenile detention center by order of the local Probate Court related to his involvement with Community Corrections, where he remained at the time of the hearing in this matter. (Exhibits A, 1-9; Testimony)

8. On November [redacted], sent Appellant an Adequate Action Notice indicating that his request for inpatient residential treatment had been denied. The notice included Appellant's rights to a Medicaid fair hearing. (Exhibit 1, p 22; Testimony).

9. Appellant's Request for Hearing was received by the Michigan Administrative Hearing System on November 6, 2015. (Exhibit 9)

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*

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 Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. NMRE contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are 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. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

The Medicaid Provider Manual provides, in pertinent part:

> **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.

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;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- 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
- 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 and Substance Abuse Chapter
October 1, 2015, pp 12-14

SECTION 12 – SUBSTANCE ABUSE SERVICES

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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 resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
October 1, 2015, p 80

[redacted] Substance Use Coordinator testified that Appellant's mother sought treatment for Appellant in November 2014 and that Appellant was thereafter placed a [redacted] for inpatient treatment. [redacted] Substance Use Coordinator indicated that following his release from [redacted], Appellant followed up with outpatient care. [redacted] Substance Use Coordinator testified that in [redacted] Appellant's mother again sought inpatient residential treatment for Appellant and, following a telephone screening, Appellant was approved for intensive outpatient treatment, but was denied inpatient residential treatment. [redacted] Substance Use Coordinator indicated that [redacted] based its decision on information provided by Appellant and his mother and relied on criteria from the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC), as required by the Medicaid Provider Manual.

[redacted] Substance Use Coordinator testified that the specific ASAM criteria that was used in Appellant's screening consisted of six dimensions: 1) withdrawal potential; 2) medical conditions and complications; 3) emotional, behavioral or cognitive conditions and complications; 4) readiness to change; 5) relapse, continued use or continued problem potential; and 6) recovery/living environment. With regard to Appellant, [redacted] Substance Use Coordinator indicated 1) that it did not appear that withdrawal management was needed at the time of the screening; 2) no medical concerns were reported; 3) high mental health needs were reported, which prompted the need for co-occurring services; 4) readiness to change could be met through outpatient services; 5) relapses seemed to occur when the mental health issues were high; and 6) Appellant had a supportive mother and living environment. Based on the screening, [redacted] Substance Use Coordinator indicated that [redacted] determined that intensive outpatient

treatment, in a co-occurring setting to address both Appellant's substance use and mental health needs, would meet Appellant's needs.

[redacted] Substance Use Coordinator testified that Appellant's mother disagreed with the results of the telephone screening, so it was decided to have Appellant come in for a full in-person assessment. However, [redacted] Substance Use Coordinator indicated that before that assessment could be conducted Appellant was placed in a secure juvenile detention center by order of the local Probate Court due to his involvement with Community Corrections. [redacted] Substance Use Coordinator testified that Appellant remained at the facility to date and that [redacted] planned to be part of the discharge planning for Appellant once he is set to be released.

On cross-examination, [redacted] Substance Use Coordinator indicated that intensive outpatient treatment would likely include at least 9 hours of treatment per week, including group and individual therapy. [redacted] Substance Use Coordinator testified that if it was determined upon assessment that Appellant needed more treatment, or even inpatient treatment, those services would be approved. [redacted] Substance Use Coordinator testified that she had spoken to Appellant's probation officer around the time of his incarceration, but had not spoken to him since that time. [redacted] Substance Use Coordinator testified that she did not know why Appellant was being detained in a juvenile detention facility, nor did she know how he was doing at the facility.

Based on the evidence presented, Appellant has failed to prove, by a preponderance of evidence that [redacted] erred in denying Appellant's request for inpatient residential treatment. Here, [redacted] E used the proper ASAM criteria via a telephone screening to determine that Appellant's needs could best be met through intensive, outpatient treatment. When Appellant's mother disagreed with the results of the telephone screening, [redacted] agreed to have Appellant come in for a full, in-person assessment. However, Appellant was incarcerated in a juvenile facility before that assessment could be completed. As such, while it still may turn out that Appellant requires further inpatient residential treatment that decision cannot be made until Appellant is released from the detention facility. [redacted] has no authority to assess Appellant while he is incarcerated and they are not responsible for his treatment during any incarceration.

If the Probate Court were to indicate that Appellant could be released from the detention facility if an alternative inpatient treatment facility could be approved, then [redacted], with permission from the Probate Court and Appellant's mother, could conduct, or have conducted, a full assessment of Appellant's needs. However, that scenario is purely speculative at this point and does not change the fact that [redacted] followed the proper procedure in conducting a telephone screen with Appellant and his mother back in [redacted].

Appellant bears the burden of proving by a preponderance of the evidence that Long Term Residential Substance Use Disorder services are a medical necessity in accordance with the Code of Federal Regulations (CFR) and Michigan Medicaid policy. Here, this Administrative Law Judge can only determine whether [redacted] decision was correct at the time it was made, based on the information available at that time. For the

reasons stated above, Appellant did not meet the burden to establish that Long Term Residential Substance Use Disorder services were medical necessary at the time of his screening.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that NMRE properly determined that Appellant was not eligible for Long Term Residential Substance Use Disorder services.

IT IS THEREFORE ORDERED that:

The NMRE decision is **AFFIRMED**.

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

Date Signed: [redacted]

Date Mailed: [redacted]

cc: [redacted]

RJM/cg

***** 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.