STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

RICK SNYDER
GOVERNOR

MIKE ZIMMER
DIRECTOR

Date Mailed: March 18, 2016
MAHS Docket No.: 15-023088

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

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

After due notice, a hearing was held on . Petitioner appeared and testified on his own behalf. , Hearing Representative/Attorney, represented Respondent , a Masters-level Psychologist and Clinical Grants and Training Specialist for Respondent; a Psychiatrist; and , Supports Coordinator; testified as witnesses for Respondent.

ISSUE

Did Respondent properly terminate Petitioner'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. On , Petitioner was released from prison on parole after serving five years for retail fraud. (Exhibit N, page 1).

2. During his time in prison, Petitioner attempted suicide multiple times; he was diagnosed with schizophrenia, which was later changed to a diagnosis of schizoaffective disorder; and he was treated with several different medications. (Exhibit N, pages 1, 4).

3. During the last ten months of Petitioner's time in prison, he was in placed in a psychiatric unit because of a suicide attempt, auditory hallucinations, and depression. (Exhibit M, page 2; Exhibit N, page 1).

4. At the time of his release, the prison doctors were also in the process of changing his medications again. (Exhibit N, page 4).

5. On the day of his release, Petitioner was pre-screened for mental health services at [redacted] [redacted] and found to have suicidal ideation, depression, and auditory hallucinations. (Exhibit N, page 1).

6. He was then diverted and recommended for outpatient services through the [redacted]. (Exhibit N, page 1).

7. [redacted] is a Community Mental Health Services Program (CMHSP) that is affiliated with the Respondent Prepaid Inpatient Health Plan (PIHP) and that contracts with services providers such as the [redacted]. (Testimony of [redacted]

8. On [redacted], Petitioner was assessed at the [redacted]. (Exhibit N, pages 1-10).

9. By that time, he had moved into an Adult Foster Care (AFC) home. (Exhibit N, page 1).

10. During that assessment, Petitioner's diagnoses were noted to be schizoaffective disorder; major depressive disorder, recurrent, unspecified; and personality disorder NOS. (Exhibit N, page 7).

11. It was also noted that Petitioner was on the medications Lamictal, Zyprexa, and Fluvoxamine. (Exhibit N, page 9).

12. The services recommended following the assessment were individual therapy and psychiatric evaluation. (Exhibit N, page 9).

13. On [redacted], Petitioner underwent a psychiatric evaluation at the [redacted]. (Exhibit M, pages 1-3).

14. During that evaluation, Petitioner's history was noted, in part, as including the following information:

> He was released from prison on Luvox, Lamictal and Zyprexa, and would like to continue on them. He has noted consistent improvement in his sleep and stabilization of his mood. He's had a long history of auditory hallucinations that are improving on Zyprexa

> and chronic dysphoria. He does state that he still has some paranoia, which he feels comes from being on guard in a prions setting.

Exhibit M, page 2

15. He was also diagnosed with (1) schizoaffective disorder, source by history, and (2) borderline personality disorder. (Exhibit M, pages 1, 3).

16. The plan was to have Petitioner continue on his current medications and follow up in three months. (Exhibit M, page 3).

17. Petitioner subsequently moved into a specialized residential home where he received around-the-clock supervision to help ensure his health and safety, including help making sure he is compliant with his medications. (Exhibit L, pages 1, 10).

18. Petitioner was also approved from services through Respondent and the ████ ████ ████ █████, including the personal care at his residential setting, medication review services, case management services, and individual therapy. (Exhibit L, page 10).

19. Petitioner was also approved for group therapy, but he only attended one meeting before he decided to stop going. (Exhibit K, page 2).

20. On October 21, 2015, Petitioner underwent another assessment at the ██████████. (Exhibit L, pages 1-11).

21. During the assessment, Petitioner reported that he has been hospitalized four times since his release from prison. (Exhibit L, page 1).

22. His most recent hospitalization was in ███████████ and was for suicidal ideation and command hallucinations. (Exhibit L, page 10).

23. Petitioner also reported that he becomes overwhelmed easily, which results in an increase in auditory hallucinations and thoughts of self-harm; and that he is trying to distinguish his own thoughts from hallucinations. (Exhibit L, pages 1, 10).

24. Petitioner further reported that his medications have reduced the intensity of the voices, but that he feels frustrated because they are not working as well as he would like. (Exhibit L, page 1).

25. His diagnoses were noted to be schizoaffective disorder, unspecified, and borderline personality disorder. (Exhibit L, page 7).

26. The clinician completing the assessment recommended that Petitioner continue with his medication reviews to monitor his stability with prescribed medications; continue with his current level of care in the specialized residential home; continue with individual therapy; and continue to receive case management. (Exhibit L, page 10).

27. The clinician also recommended that Petitioner be considered for Dialectical behavior therapy (DBT) and peer support services. (Exhibit L, page 10).

28. On [redacted], Petitioner was again admitted to the hospital for suicidal thoughts and other symptoms. (Exhibit K, page 2).

29. On [redacted] [redacted] [redacted], Petitioner had a meeting with supports coordinator, who noted that Petitioner had been hospitalized seven or eight times since [redacted]. (Exhibit K, page 2).

30. The supports coordinator also noted that same issues have been present since at least [redacted], when the supports coordinator started, and that there has to be something that can be done to stop Petitioner's feelings that he needs to go to the hospital because of his borderline personality disorder. (Exhibit K, page 2).

31. The supports coordinator further noted that he suspects that Petitioner's residence's staff overreact to any suggestion by Petitioner toward suicidal ideation and that, if Petitioner left the specialized residential home, Petitioner would be on his own and that the Department would not pay for his living expenses. (Exhibit K, page 2).

32. The supports coordinator also wrote that Petitioner's upcoming medication review may determine course of action for now and the future. (Exhibit K, page 2).

33. On [redacted] and Petitioner met to complete a medication review. (Exhibit B, pages 1-3).

34. However, the review was not completed after Petitioner became upset and left. (Exhibit B, page 3).

35. Following that review, [redacted] findings included:

> The patient has seen many physicians so far, and he ends up not wanting to see them or objecting to their treatment and has been quite problematic. I spoke with case managers and the psychiatrist who recently treated him prior

to the appointment and after the appointment, trying to clarifying [sic] the findings. I spend almost an hour going over everything in the records.

He was hospitalized locally 4 times already . . . All of them were either because of suicidal attempt or suicidal ideation, claiming to be hearing voices. Almost every admission without fail he would argue above need for hospitalization, wanting to get out, and did not really cooperate. One of the things which he has focused on quite a bit was wanting to go to [REDACTED].

* * *

The impression from the psychiatrist at the local hospital was that he's just a character disorder and mood disorder is secondary to Axis II issue, and that was the reason for the last 3 hospitalizations. He was not kept any more than 2 days at last hospitalization, and every hospitalization was shorter than the 1 before for the same reason. He desperately wanted to be in the hospital in [REDACTED] in [REDACTED], but as soon as he was interviewed he demanded to be released and within a few days he was released.

He had seen [REDACTED] for psychiatric evaluation in [REDACTED]; that was since his release from prison. He then saw [REDACTED] in [REDACTED]h [REDACTED] as he lived in a foster home in [REDACTED]s after one of the hospitalizations. After hospitalization he moved into a more secure home and had an appointment to see Nurse Practitioner [REDACTED] on [REDACTED] Before he even saw her he refused to see her. He saw [REDACTED] twice, and came a third time to announce that he is not going to see her and just walked out of the office. Prior to that, he wanted to be taken off medication, which she indulged him and every request he had. Interestingly, even though he stated that he

didn't want to take any medication and was granted that choice, he ended up taking Zyprexa because he couldn't sleep.

I looked at the list of medications he has taken so far, which includes Luvox, Lamictal, Zyprexa, Clozaril, Risperdal, Celexa, Xanax, Wellbutrin, trazodone, Cogentin, and Artane, and he was never happy with any of these.

* * *

I reviewed a few more details and made a decision that he does not need any prescriptions not medications ever made any sense nor likely to take care of his problem, which is mostly Axis II issues. I spoke with ███ ████ at length, who also agrees that there is a huge character issue, and he is not likely to cooperate no matter what we do. Whether we do anything or not, his suicidal attempts will continue as that is the trump card he seems to be using, even though he never really seems depressed or suicidal within a few hours after he claims that. There were times he would come to the emergency room indicating that he's suicidal and distressed and hearing voices, but calmly sitting and watching TV and drinking coffee.

OBJECTIVE: During the appointment he seemed not particularly happy to be here, and he already made a decision that he is not going to see me, and he just was looking for some reason to blow off, which he did. There was no mention of any psychosis, any genuine mood disorder, anxiety, depression, or suicidality. Most of the time it is his comments how he was, but that seems to dissipate as soon as he gets want he wants. His affect was very blunted. He seemed very paranoid and suspicious in his behavior, and behavior is consistent with a person who has been warned to behave during the appointment as I'm the last person that's left here that can see him. None of this seemed to really matter as he has

> learned the art of manipulating people with his suicidal intent and attempts when in fact we have nothing that we can do to change this pattern . . . In my judgment with all the information I gathered, he is basically a severe Axis II who creates dangerous scenarios but there is nothing we can do to change that because he seems to be doing that even though he's on medication in a very secure, extremely supervised specialized foster home at this point, and he did the same thing while in position despite whatever medication may or may not have been.

Exhibit B, pages 2-3

36. Based on those findings, [redacted] concluded that the diagnosis of schizoaffective disorder should be removed. (Exhibit B, pages 1-3).

37. He also concluded that Petitioner's diagnoses included borderline personality disorder; malingerer, conscious simulation; other persistent mood affective disorder; and antisocial personality disorder. (Exhibit B, page 1).

38. [redacted] further noted the following plan:

> PLAN: No prescription given nor did I feel the need for it. I do not believe that he needs any medication that would make any substantial change in his behavior. No follow up appointment given. Will be discussing in special core team to decide what further to do or not do with this patient. My suggestion is to give him the option of going into DBT, which he already refused, and we may have to sit down with patient to indicate what his choices are once we make a decision on what we can and cannot do.

Exhibit B, page 3

39. On [redacted] the [redacted] sent Petitioner written notice that his medication review services would be terminated on [redacted] because the service is not medically necessary. (Exhibit 1, page 2; Exhibit D, page 1).

40. The termination took effect on [redacted]. (Testimony of Petitioner; Testimony of Hart).

41. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the termination of medication review services. (Exhibit 1, pages 1-2).

42. In [redacted], Petitioner moved from his specialized residential home to an AFC home. (Exhibit I, pages 1-2).

43. The move was based on the determination that Petitioner does not have an Axis I diagnosis or a need for the specialized residence. (Exhibit I, page 2).

44. On [redacted], Hart conducted a Utilization Review of Petitioner's services and appeal. (Exhibit E, pages 1-7).

45. After that review, she agreed that Petitioner's medication review serviced should be terminated because, after his diagnosis was changed, Petitioner had no need for medication or ongoing psychiatric services. (Exhibit E, page 7).

46. During a [redacted] meeting with his supports coordinator, the supports coordinator noted that Petitioner was no longer being prescribed any medications, but appeared to be stable and there were no known incidents reported. (Exhibit H, page 2).

47. He also noted that, while Petitioner had been referred for DBT therapy, no contact had yet been made by the DBT therapist. (Exhibit H, page 2).

48. On [redacted], Petitioner's supports coordinator noted that Petitioner had his initial DBT session, with the therapist scheduling two more appointments, and that Petitioner seemed to be doing well at his new AFC home, with no incidents reported. (Exhibit G, page 2).

49. On [redacted], Petitioner reported anxiety over his upcoming hearing, depression, a lack of self-esteem, and suicidal thoughts to his supports coordinator. (Exhibit F, page 2).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…

42 USC 1396n(b)

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 (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving medication review services through Respondent and its affiliated CMHSP Berrien County Mental Health Authority.

With respect to such services, the Medicaid Provider Manual (MPM) provides:

> **3.17 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, October 1, 2015 version
Mental Health/Substance Abuse Chapter, page 19

However, while medication review is a covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the MPM also 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.

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.

MPM, October 1, 2015 version
Mental Health/Substance Abuse Chapter, pages 13-14

In this case, Respondent terminated Petitioner's medication review services on the basis that they were not medically necessary.

In support of that decision, Hart testified that she reviewed the case after Petitioner filed his request for hearing and that she agreed with the determination given that Petitioner continued to have the same, if not worsening, symptoms over the course of time with Respondent and that the medications were clearly not effective. She also testified that Petitioner would be better served with supports coordination, peer support services and outpatient DBT, all of which he is now receiving.

[redacted] testified that, by the time he saw Petitioner for the first and only time, Petitioner had gone through a number of medications and doctors, but nothing was successful and, if anything, the medications seems to destabilize Petitioner. [redacted] also testified that, upon his review of Petitioner's case, he found that Petitioner was improperly diagnosed with schizoaffective disorder and that Petitioner only has personality disorders that cannot be treated with medications.

[redacted]d testified that, since the action in this case, Petitioner attended two outpatient DBT sessions, but also missed one because he was hospitalized again.

In response, Petitioner testified that he has had mental problems his entire life and has been both prescribed multiple medications, some of which he had to switch from due to severe side effects and been treated by multiple doctors, including some that he had to switch from because they did not have his best interests at heart. He also testified that he ended up with [redacted], but the doctor disrespected him, Petitioner had to walk out, and no assessment was ever done. Petitioner further testified that, despite no assessment being done, [redacted] and Respondent cut off his medications cold turkey. Petitioner also testified that, since the termination, the voices in his head have gotten worse, he has difficulty sleeping and headaches, and he had to be hospitalized once.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in terminating his medication review services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed. Pursuant to the above policy, a PIHP may deny services that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care or for which there exists another appropriate and efficacious service that otherwise satisfies the standards for medically-necessary services. Here, it is clear that the medications and medication review services have been ineffective in assisting Petitioner given that, despite multiple medications, multiple doctors and Petitioner living in restrictive and specialized settings, Petitioner's symptoms have not gotten better and appear to have worsened. Moreover, [redacted] also credibly testified as to why the medications were not working and will never work, how Petitioner was misdiagnosed in the past, and what offered therapeutic

services will better assist him while, in response, Petitioner only offered broad claims that he needs the medications and that his doctors, including [redacted], have continued to fail him.

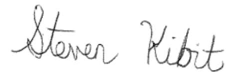
Accordingly, in light of the clear ineffectiveness of the medication review services and [redacted] credible testimony regarding the inappropriateness of the services, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must be affirmed.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED**.



SK/db

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

DHHS Department Rep.

DHHS-Location Contact

Petitioner