RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: January 31, 2017
MAHS Docket No.: 16-016184
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Janice Spodarek

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 January 4, 2017. Petitioner appeared and testified. [redacted], Case Manager with Recovery Technology appeared as a witness on behalf of Petitioner. [redacted], Fair Hearings Officer appeared on behalf of the Department of Health and Human Services subcontractor, [redacted] Community Mental Health (CMH), (Respondent, Department or CMH). [redacted], RN Utilization Manager, and [redacted], MA Psychological Utilization Management with the Respondent appeared as witnesses.

ISSUE

Did CMH properly deny Petitioner's request to continue receiving services from the Respondent's psychiatrist for medication issuances?

FINDINGS OF FACT

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

1. Petitioner is a 53 year-old Medicaid beneficiary, diagnosed with unspecified Schizophrenia Spectrum and other psychotic Disorder with alcohol use disorder, mild, as secondary. (Exhibit A.1).

2. On October 4, 2016, a request for the continuation of Psychiatric Services was received from Recovery Technology. The Psychiatric services were being transferred from [redacted] to [redacted] due to [redacted] no longer offering psychiatric services. (Exhibit A.1).

3. On 10/10/16 the Respondent issued a denial notice stating that Petitioner "…has been stable for over 4 years without medication changes" and furthermore that Petitioner's condition has been stable for years. The Respondent recommended that Petitioner see his Primary Care Physician (PCP) for continuing scripts, as such is within the scope of a PCP's practice. (Exhibit A.1; Testimony).

4. On 11/14/16 Petitioner filed a request for hearing stating that he did not feel that he is at the level where he can think normally. (Exhibit 1)

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 (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. CMH contracts with the Michigan Department of Health and Human Services to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only 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. *See 42 CFR 440.230.* Medical necessity is defined by the Medicaid Provider Manual as follows:

> **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.
- 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; 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;
    - 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
April 1, 2015, pp 12-14

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports.

Justification as to whether case management is needed or not must be documented in the beneficiary's record.

Medicaid Provider Manual
Mental Health and Substance Abuse Chapter
April 1, 2015, pp 82-84

The Respondent indicated that the primary authority for denying Petitioner's request for ongoing psychiatric services is found in the MPM, Mental Health and Substance Abuse Chapter, Section 2.5.D-PIPH decisions, wherein it states that a PIHP may deny services for which there exists another appropriate, efficacious, less-restrictive and cost-effective services, setting or support that otherwise satisfied the standards for medically-necessary services. (See above, Medicaid Provider Manual, October 1, 2016, page 14.)

Here, the Petitioner argues that he is not stable, and, that his PCP is not comfortable with making any adjustments to his medication.

The Respondent argues that evidence indicates that Petitioner is stable, and that such medication issuances are within the scope of a PCP's practice.

Petitioner has the burden of proof, by a preponderance of evidence, to establish eligibility for the program(s) in dispute. This means that Petitioner must bring forth relevant evidence to show eligibility that is contrary to the action taken by the Respondent, and likewise, that the Respondent's actions were not supported by credible and substantial evidence. Petitioner must also bring forth evidence of law, policy or rules that would entitle Petitioner to the relief or benefits for which Petitioner complains.

Here, Petitioner offered no evidence that his condition is not stable. Nor did Petitioner offer any evidence from his PCP that s/he was not comfortable in prescribing such medication. As pointed out by the Respondent, such medication issuances are within the scope of practice of a PCP, and absent any evidence to the contrary, it must be assumed that a PCP can and would prescribe the same. Petitioner failed to meet his burden of proof based on the evidence here and thus, the action must be upheld.

It is noted that Petitioner has other services he receives from the CMH and, that this decision in no way affects Petitioner's eligibility for continuing or other services he receives from the CMH other that the issue reviewed herein.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

> The CMH properly denied Petitioner's request for continuing services from the psychiatrist and thus,

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**

Janice Spodarek

JS/cg

Janice Spodarek
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

Petitioner [redacted]

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

DHHS Department Rep. [redacted]