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: March 27, 2017
MAHS Docket No.: 17-000883
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 March 15, 2017. Petitioner [redacted] appeared on behalf of the Petitioner. [redacted], [redacted] customer Services, Fair Hearings Officer; [redacted], Psychologist, Supervisor of Utilization Management represented the [redacted] Community Mental Health ([redacted] or Respondent).

Respondent's Exhibit A - G (pages 1 – 26) were admitted as evidence.

ISSUE

Did [redacted] Community Mental Health properly deny Petitioner's request for psychiatric 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. Petitioner is a [redacted]-year-old male who carries a diagnosis up after 33.2 Major Depressive Disorder, recurrent episode, severe. He was prescribed Prozac 20 mg in the a.m. and Trazodone 50 mg at bedtime for insomnia (Exhibit A)

2. Petitioner lives independently in the community.

3. On October 24, 2016, [redacted] received an authorization request for the continuation of psychiatric services by the provider [redacted]. The request stated that Petitioner's general practice treating physician would not prescribe any psychiatric medications and that he would need to be seen by a psychiatrist.

4. Psychiatric services were being transferred from Recovery Technology to [redacted] Medical Services due to Recovery Technology no longer offering psychiatric services.

5. On October 24, 2016 the request for psychiatric services was denied by [redacted] Utilization Manager, who stated, “A primary care physician can prescribe Prozac and Trazodone. I do not see any documentation in the chart stating that the primary care physician has refused to prescribe these medications. Consumer should be transferred to his primary care physician as there is no medical necessity to see a psychiatrist.” (Exhibit B)

6. On October 24, 2016, denial notice and hearing rights form was mailed to Petitioner. The reason for the action is that the documentation provided does not established medical necessity (Exhibit D).

7. On October 25, 2016 a letter from the primary care physician indicates that the position preferred that [redacted] provide psychiatric medications.

8. On December 16, 2016, a request for local appeal was received stating: “my primary care doctor has stated that he would preferred that a psychiatrist prescribed the needed psychiatric medication. Due to my numerous physical health and mental conditions. I need a psychiatrist who knows about any potential medication interaction that may occur with my physical health medications.” (Exhibit E)

9. [redacted] Utilization Manager Supervisor received the appeal and upheld the decision to deny the psychiatric services.

10. On January 23, 2017, resolution/disposition was completed and mail to Petitioner stating: psychiatric evaluation and ongoing medication services are denied due to documentation not being present to support the medical necessity of services. It is customary within the standard of care for primary care physicians and therapists to evaluate and treat anxiety and depression syndromes. It is within the primary care position scope of practice to prescribe necessary medications. Michigan Medicaid Provider Manual requires that services be provided in the least restrictive most cost-effective setting possible according to professional standards of care. It is therefore reasonable to require attempts by primary providers prior to approving specialty care. The letter from the primary care physician that is scanned in the record indicates that they support treatment continued by psychiatrist, it does not state they would not be able to provide this care if it were appropriately transferred. (Exhibit F)

11. On January 31, 2017 the Michigan Administrative Hearing System received a request for hearing to contest the negative action where and Petitioner stated that my primary care physician does not want to prescribe my psychiatric

medication that my previous psychiatrist prescribed. Now [redacted] is denying the new psychiatrist because of funding issues and my previous psychiatrist had to leave because of financial issues as well. I feel like I need to see a psychiatrist because I'm still dealing with the issues.

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).

The Michigan Mental Health Code explicitly states:

330.1712 Individualized written plan of services.

Sec. 712.

(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975 ;-- Am. 1995, Act 290, Eff. Mar. 28, 1996 ;-- Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997

The Michigan Mental Health Code, Section 330.1100a, defines developmentally disabled as:

(21) "Developmental disability" means either of the following:

(a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:

(i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
(ii) Is manifested before the individual is 22 years old.
(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:

(A) Self-care.
(B) Receptive and expressive language.
(C) Learning.
(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency.

(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

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,
Behavioral Health and Intellectual and
Developmental Disability Supports and Services,
January 1, 2017, pp 13-14

In the instant case, Petitioner testified on the record that he continues to need psychiatric services which his primary care physician prefers not to provide. He feels that [redacted] is denying psychiatric services strictly because of financial and funding reasons.

Respondent's representative indicates that psychiatric evaluation and ongoing medication services are denied due to documentation not being present to support the medical necessity of services. It is customary within the standard of care for primary care physicians and therapists to evaluate and treat anxiety and depression syndromes. It is within the primary care position scope of practice to prescribe necessary medications. Michigan Medicaid Provider Manual requires that services be provided in the least restrictive most cost-effective setting possible according to professional standards of care. It is therefore reasonable to require attempts by primary providers

prior to approving specialty care. The letter from the primary care physician that is scanned in the record indicates that they support treatment continued by psychiatrist, it does not state they would not be able to provide this care if it were appropriately transferred.

Based on the evidence presented, CMH did properly deny Petitioner's request for psychiatric services. As indicated above, all services must be medically necessary, meaning those services are, "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."

The burden of proof is on Petitioner to prove by a preponderance of the evidence that [redacted] psychiatric care is required in medically necessary for him to continue his medication regimen. The Respondent has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with Medicaid and Department policy when it determined that Petitioner would not be eligible to receive psychiatric services because they are not currently medically necessary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondents determination to deny psychiatric care is in compliance with medical necessity criteria under the circumstances.

IT IS THEREFORE ORDERED that

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

LL/sb

Landis Lain
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

Authorized Hearing Rep. [redacted]

DHHS -Dept Contact [redacted]

Petitioner [redacted]

DHHS Department Rep. [redacted]