

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

██████████,

Appellant

_____ /

Docket No. 2009-13161 CMH

Case No. ██████████

Load No. ██████████

DECISION AND ORDER

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

After due notice, a hearing was held on ██████████. ██████████ appeared on behalf of her daughter, ██████████ (Appellant).

██████████, appeared on behalf of the ██████████ ██████████ an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded mental health supports and services (hereafter, 'Department'). Also appearing as witnesses for the Department were ██████████

ISSUE

Has the Department appropriately denied coverage for the Appellant's inpatient stay at ██████████ for the period ██████████, through ██████████

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a ██████-year old Medicaid beneficiary with medical/mental health diagnoses of depression with increasing suicidal ideation, exacerbation of mood disorder, and bipolar disorder. (*Exhibit 1, p. 23*)

2. On [REDACTED], the Appellant was admitted to [REDACTED] to the inpatient unit of this facility. Her admitting diagnoses included mood swings, depression, agitation and threatening gestures. At the time, she denied hallucinations or serious illness. [REDACTED], the Appellant's primary insurance carrier, paid for her stay through [REDACTED].
3. Because of difficulty finding suitable placement, and, because the Appellant's adoptive mother refused to pick up the Appellant on [REDACTED], the date that a [REDACTED] physician charted she was ready for discharge, the Appellant remained at [REDACTED] through [REDACTED], at which time she was discharged to a residential placement arranged through the [REDACTED] Department of Human Services.
4. A retroactive review was submitted by [REDACTED] to [REDACTED] on [REDACTED], seeking payment for the Appellant's inpatient hospitalization from [REDACTED], until [REDACTED]. [REDACTED] denied payment after concluding the Appellant did not satisfy medical necessity criteria for inpatient hospitalization during this period.
5. On [REDACTED], an Adequate Negative Action Notice was issued to the Appellant's mother indicating that coverage for the period [REDACTED], through [REDACTED], was denied.
6. On [REDACTED], the Appellant's mother filed her Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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 operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) HSW. [REDACTED] contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

In addition to the criteria outlined in the Medicaid Provider Manual, the Code of Federal Regulations *42 CFR 440.230* states that Medicaid beneficiaries are only entitled to medically necessary **Medicaid-covered** services, provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

The Medicaid Provider Manual, Mental Health/Substance Abuse chapter provides a listing of the Medicaid covered services WCCSTS may provide. With regard to "covered services," Section 3 states, in pertinent part, as follows:

Section 3 - Covered Services

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation/Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDCH has

designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children's Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services.

In determining whether to grant or deny the Appellant's requests, WCCSTS must apply the Department's medical necessity criteria. The Department's policy for medical necessity is 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. (Emphasis supplied by ALJ)*

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.

*Medicaid Provider Manual, Mental Health/
Substance Abuse, Version Date: April 1, 2008;
Section 2.5. Page 12-14.*

Inpatient Psychiatric Hospital Admissions are Medicaid-covered services. The Medicaid Provider Manual, Mental Health/Substance Abuse chapter, details the eligibility requirements for this service:

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.

- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services. In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay. If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDCH and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

8.5 ELIGIBILITY CRITERIA

8.5.A. INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.

- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that co-exist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.C. INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level

of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM Axis I, or ICD diagnosis (not including V Codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)

At least **one** of the following manifestations is present:

- Severe Psychiatric Signs and Symptoms
- Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
- Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
- Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.
- Disruptions of Self-Care and Independent Functioning
- Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
- The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.
- Harm to Self
- A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.
- There is a specific plan to harm self with clear intent and/or lethal potential.
- There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.
- There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
- There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan

and judgment would suggest an inability to maintain control over these ideations.

- There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
- Harm to Others
- Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
- There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
- There has been significant destructive behavior toward property that endangers others, such as setting fires.
- The person has experienced severe side effects from using therapeutic psychotropic medications.
- Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care
- The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or re-initiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
- There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.

Intensity of Service The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following:

- Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.
- Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.
- Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

- A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms

8.5.D. INPATIENT PSYCHIATRIC CARE – CONTINUING STAY CRITERIA: ADULTS, ADOLESCENTS AND CHILDREN

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services. (Emphasis supplied by ALJ)

The individual must meet all three criteria outlined below:

Diagnosis The beneficiary has a validated current version of DSM Axis I or ICD mental disorder (excluding V codes) that remains the principal diagnosis for purposes of care during the period under review.

Severity of Illness (signs, symptoms, functional impairments and risk potential)

- Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care.
- Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment.

- Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment.
- Continued significant self/other harm risk.
- Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring.
- Emergence of new signs, symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.

Intensity of Service

- The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications.
- The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.
- Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.
- The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

***Michigan Department of Community Health
Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: April 1, 2009
Pages 41-48***

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenber*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its

nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

The preponderance of evidence presented establishes the Appellant was admitted to an inpatient psychiatric setting on [REDACTED] after threatening to assault a relative following an argument. The Appellant presented to [REDACTED] with a history of behavioral, emotional, academic and social difficulties, and a history of substance abuse. She admitted to experimenting with alcohol and marijuana but denied recent use of these substances, and further admitted to having mood swings with poor anger and impulse control. (*Exhibit 1; p. 18*)

The preponderance of evidence presented further establishes that, upon admission to the inpatient psychiatric setting, the Appellant acknowledged threatening her sister, but denied having any current suicidal ideations or hallucinations. Her mental status examination upon admission reveals fair hygiene and grooming, fair eye contact, flat affect, irritable mood, but that her thought processes were logical and goal directed, and, although thought content had increased defensiveness, it was not delusional. (*Exhibit 1; p. 19*)

The Appellant's mother complained that [REDACTED] inappropriately refused to pay the bill, complained that she could not afford the cost of hospitalizing the Appellant, and further asserts that the Appellant was not ready for discharge on [REDACTED], due to continued negative behaviors and DHS placement issues.

The Appellant's mother presented no evidence-based medical documentation challenging and/or contradicting the professional conclusions of health care providers who examined the Appellant while she was a patient at [REDACTED]. Furthermore, above-cited policy clearly provides that inpatient hospitalization may not be continued due to placement issues.

Based on a preponderance of evidence presented, I must therefore conclude the Appellant no longer met medical necessity criteria for Medicaid-funded inpatient psychiatric hospitalization

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between [REDACTED], and [REDACTED]. As such, [REDACTED] is not obligated, pursuant to its contract with the Department, to pay for the costs incurred during this period.

DECISION AND ORDER

I decide that [REDACTED] appropriately denied inpatient hospitalization coverage for the period [REDACTED], through [REDACTED]

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

[REDACTED]

Date Mailed: 4/22/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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.



