STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-19252 CMH
Case No. [redacted]
Load No. [redacted]

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 [redacted]. [redacted] appeared on behalf of her [redacted] (Appellant).

[redacted], and [redacted], appeared on behalf of [redacted], an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded mental health specialty supports and services (hereafter, 'Department').

ISSUE

Has the Department appropriately denied the Appellant request for payment of inpatient psychiatric crisis residential services?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid beneficiary who is a recipient of services through the auspices of [redacted] as the Community Mental Health Services Provider (CMHSP). He has a Primary Axis I diagnosis of Oppositional Defiant Disorder, secondary diagnosis of Intermittent Explosive Disorder, and tertiary diagnosis of Mood Disorder, NOS. *(Exhibit 1; p. 20)*

2. On [redacted], the Appellant was evaluated for determination of medical need for psychiatric inpatient services. At that time, he was found eligible for inpatient care and placed at [redacted].

3. Following his hospitalization at [redacted], the Appellant was

placed in a juvenile detention center in [redacted]. On [redacted], he was again evaluated for inpatient services. At this time, he did not meet eligibility criteria for inpatient hospitalization and was thereafter placed in the [redacted], where he presently resides.

4. The [redacted], emergency screening for inpatient psychiatric hospitalization contains the following comments:

> *[redacted] is a [redacted], who appears younger than his stated age and is small in stature who is currently housed in [redacted]. He has had no difficulties since being at [redacted]. He was recently discharged from [redacted] following an increase in aggression and violence after he was reportedly discontinued from psychiatric meds. Prior to hospitalization, he was residing in [redacted] in [redacted].*
>
> *[redacted] describes his mood as "happy" as reports that he is feeling better now then he has in a long time. He states that he is eating and sleeping well. [redacted] has insight into his situation. Admits to history of aggression and violence but states that most recently this was when he [had] been off his mediations (sic). [redacted] expresses concern about returning home to his mothers home. He states that he would then be home alone all day long and would be in charge of watching his two younger siblings. He states that this would result in him becoming frustrated and him possibly becoming physical with his siblings. States that he would like to reside with his grandparents in [redacted]. He states that this would allow him to be close to [redacted] where he would like to get his outpatient treatment. He states that his grandparents are extremely supportive and reports that he gets along well with them. He states that he has never had trouble controlling his anger with his grandparents. He was able to recognize that he may still have anger issues but feels he will do much better with them."*
>
> *"…"*
>
> *(Exhibit 1; p. 20)*

5. The [redacted], [redacted] contains the following comments:

> *"The patient was given his Adderall the second day that he was here and there was dramatic change in the patient's personality. Instead of being the euphoric, giggling young man that we had the day before, instead he was extremely irritable and angry. It was felt that he might be made worse by Adderall in terms of his irritability. Because of that Adderall was stopped and the patient was placed on Strattera. The patient did fairly well on the Strattera appearing to be able to concentrate much better than he did the first day when he received no medications.*

> *The behavior was discussed with [redacted] who is the child's psychiatric consultant for [redacted] and who has followed the patient in the past…" "…The patient generally did fairly well on the ward. Once he was on medications, he tended to settle down. Despite the fact that we had another very explosive young man on the ward for much of the time he was here, the patient managed to stay out of struggles with the other boy. Because of the discussion being carried on over where the patient should be treated at the time of discharge, we requested our psychologist, [redacted], to evaluate the patient to try to get some diagnostic clarification. [redacted] felt that the screening for cycling mood symptoms indicated features of an atypical mood disorder with rapid cycling and felt that the patient met criteria for a bipolar disorder not otherwise specified. The patient also has genetic loading for severe antisocial personality disorder and schizophrenia.*
>
> *…The patient did do well on our ward although generally he was not very demanding we are an acute crisis intervention oriented unit and generally there is not time to get to the patient's schoolwork and so. It was felt that ongoing close monitoring of the patient's medication along with longer term environmental treatment could be useful for this young man."*
>
> *" . . ."*
>
> *(Exhibit 1; p. 33)*

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 [redacted] 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, [redacted] 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.

Crisis Residential Services are Medicaid-covered services. The Medicaid Provider Manual, Mental Health/Substance Abuse chapter, details the eligibility requirements for this service:

Section 6 - Crisis Residential Services

Crisis residential services are intended to provide a *short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. (Emphasis added)* Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;

- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

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 Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied that 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).

The Michigan Supreme Court defines proof, by a preponderance of the evidence, as requiring 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).

Medicaid covered crisis residential services are not long-term services, but rather, short-term alternative placements available only to individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This service does not include room and board costs.

The evidence presented establishes the Appellant was hospitalized at [redacted], which resulted in discharge following an amelioration and diminishment of behavioral symptoms. The evidence further establishes the Appellant's behaviors have shown marked improvement in structured settings, and that, once discharged from these settings and released into the community, his behaviors decline to an extent that he is capable of adjusting to different settings, with particular note that he is apparently doing well at the [redacted]. Thus, a conclusion may be drawn that the residential setting may not, in fact, be the best, most cost-effective, placement alternative for the Appellant at this particular time, because his behaviors appear to have improved since he left [redacted].

The Appellant's mother claims the Appellant requires continued inpatient psychiatric treatment, specifically, at the [redacted]. However, she presented no evidence that his behaviors are worsening in his current placement. She also failed to establish, by a preponderance of the evidence, that inpatient crisis residential services remain medically necessary, or that a lesser

restrictive setting may not address and ameliorate his residual behavioral issues.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the Department's denial of payment for inpatient psychiatric crisis residential services is appropriate at this time.

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: 6/22/2009

***** 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.