STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-24845 CMH
Case [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], Authorized Representative and Court-Appointed Guardian, appeared on behalf of [redacted] (Appellant). Also appearing as a witness for the Appellant was her [redacted]

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

ISSUE

Has the Department appropriately denied the Appellant's request for Medicaid-funded long-term residential placement?

FINDINGS OF FACT

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

1. The Appellant is an adult Medicaid beneficiary who is diagnosed with Bipolar Disorder, Dependent Personality Disorder, Diabetes, Hypertension and Hyperlipidemia. *(Exhibit 1; hearing summary and pp. 14-15)*

2. The Appellant has resided independently for approximately [redacted]. She was hospitalized at [redacted], [redacted] (PMU) from [redacted]. The Appellant is also receiving services from [redacted], an agency contracted with [redacted], and is part of the [redacted].

3. A [redacted] case consultation indicates the Appellant recently spent almost [redacted] inpatient, including a combination of [redacted]. The Appellant has conveyed her wish to remain in her apartment, but does not adequately manage her diabetes or hypertension. This has caused many of the individuals treating her to request placement in a long-term residential facility. *(Exhibit 1; p. 15)*

4. The Appellant demonstrates poor understanding of the seriousness of her medical conditions, but is otherwise able to care for her daily needs. Her physical health has deteriorated significantly over the last 18 months to 2 years. Previous to this time, she lived successfully for many years with targeted case management services. In [redacted], she was transferred to an [redacted]. *(Exhibit 1; p. 15)*

5. On [redacted], the Appellant 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. MCCMH contracts with the Michigan Department of Community Health to provide Medicaid State Plan Specialty Supports and Services.

My jurisdiction in this case is restricted to a determination of whether the Department has appropriately denied the Appellant's request for long-term residential placement to address her deteriorating physical health.

Crucial to a determination of whether the Department's denial of an assessment for long-term residential placement in a community living facility, is whether such placement is a Medicaid-covered service, either under the State Plan, or as a B3 additional mental health service. If the requested placement is not a Medicaid-covered service, then the Department's contracted agent, in this instance, [redacted], is not required, and, in fact, is prohibited, from approving the same.

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 MCCMH 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.

Medicaid covered crisis residential services are not long-term services, but rather, are short-term services and are only available 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 demonstrates that the Appellant has benefited from short-term hospitalization in the past, and that her behaviors have been addressed in that setting. There is no evidence she meets criteria for this service at the present time.

[redacted] may also authorize, as a Medicaid-covered service, intensive/crisis stabilization services. Medicaid Provider Manual, Mental Health/Substance Abuse, Section 9, pages 50-51 lists the services as:

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis team and designed to provide a *short-term alternative to inpatient psychiatric services*. *(Emphasis added)* Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

9.3 SERVICES

Intensive/crisis services are intensive treatment interventions delivered by an intensive/crisis stabilization treatment team, under psychiatric supervision. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);
- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

9.2 POPULATION

These services are for beneficiaries, who have been assessed to meet criteria for psychiatric hospital admissions but whom, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay. (Emphasis added)

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance abuse disorder or developmental disability.

The evidence presented clearly indicates that [redacted] has authorized in-patient crisis stabilization services in the past, and that those admissions have been of benefit to the Appellant's primarily behavioral issues, which appear from the evidence to relate to her inability and/or refusal to properly monitor her diabetes and hypertension.

[redacted] may also authorize, as a Medicaid-covered service, Partial Hospitalization Services for adults. The Medicaid Provider Manual, Mental Health/Substance Abuse, Section 10, page 54 provides, in pertinent part, as follows:

Section 10.1- Partial Hospitalization Admission Criteria: Adults

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that

routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs.

The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Additionally, [redacted] may authorize, as a Medicaid-covered service, inpatient psychiatric services for adults.

INPATIENT ADMISSION CERTIFICATION CRITERIA: ADULTS

Inpatient psychiatric care may be used to treat a mentally ill person who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based upon the assumption that the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are 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.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness, reflected in a primary, validated, DSM-IV Axis I, or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Severe Psychiatric Signs and Symptoms

- Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor

retardation, resulting in extensive interference with activities of daily living so the person cannot function at a lower level of care.

- Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.

- A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

B. Disruptions of Self-Care and Independent Functioning

- The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.

- There is evidence of grave impairment in interpersonal functioning and/or extreme deterioration in the person's ability to meet current educational/ occupational role performance expectations.

C. Harm to Self

- Suicide: Attempt or ideation is considered serious by the intentionality, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.

- Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. 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.

- Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

D. Harm to Others

- Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.

- There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).

- There has been significant destructive behavior toward property that endangers others.

E. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

- The person has experienced severe side effects of atypical complexity from using therapeutic psychotropic medications.

- The person has a known history of a psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the adjustment or re-initiation of medications following discontinued use requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.

- There are concurrent significant physical symptoms or medical disorders that 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.

III. 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:

A. Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

B. Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

C. Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the consumer, others, and/or property, or to contain the consumer so treatment may occur.

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

INPATIENT PSYCHIATRIC CARE - CONTINUING STAY CERTIFICATION: ADULTS, ADOLESCENTS, AND CHILDREN

After a consumer has been certified for admission to an inpatient psychiatric setting, services will 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, arresting 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 patient'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 that justified the patient'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 that 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.

CRITERIA

I. Diagnosis:

The consumer has a validated DSM IV Axis I or ICD-10 mental disorder (excluding V codes), which remains the principal diagnosis for purposes of care during the period under review.

II. Severity of Illness:

Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to this level of care, and that 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; and

- emergence of new signs/symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.

III. Intensity of Service

The consumer 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 consumer is receiving active, timely, intensive 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 consumer 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 major 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 consumer's record.

Medicaid Managed Specialty Supports and Services
Concurrent 1915(b)/(c) Waiver Program FY 03-04:
ATTACHMENT P 3.3.2 – 10/01/02

Has the Department appropriately denied the Appellant's request for Medicaid-

funded long-term residential placement?

The Appellant's Guardian is requesting long-term, 24 hour supervised treatment, in a structured residential setting. From a review of the record, the request for long-term placement is for the specific purpose of monitoring the Appellant's medical, not mental condition(s). Although the guardian's intentions in this regard cannot be anything other than sincere and in the Appellant's best interest, a thorough review of the Medicaid Provider Manual leads me to conclude that in-patient psychiatric service is the only Medicaid covered service that would provide 24 hour per day treatment, but not necessarily long-term. Long-term residential placement in a structured settlement is not otherwise a covered service.

The evidence presented also militates against a conclusion that the Appellant's mental illness renders her incapable of attending to activities of daily living. Although it appears she must be monitored in terms of properly controlling her diabetes and hypertension, there is no evidence she is incapable of doing so, and furthermore, no evidence she is incapable of attending to other activities of daily living.

Furthermore, the record is devoid of evidence that the Appellant is at a continued significant risk of self-inflicted harm or harm to others, or that her use of psychotropic medications, if any, at dosage levels necessitate medical supervision, dosage titration of medications requiring skilled observation. There also is no evidence that the Appellant's medications result in adverse biologic reactions requiring close and continuous observation and monitoring, or that she displays new signs/symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.

Lastly, there is no evidence the Appellant requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, in order to assure her basic needs are met, or to manage biologic/medication complications.

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 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).

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).

Ultimately, the Appellant's guardian failed to present medical documentation effectively

contradicting the Department's assertions that long-term residential placement in a 24-hour structured, supervised setting is not a Medicaid-covered service, or that she meets criteria for coverage of inpatient hospitalization at this time.

While authorized [redacted] services may be provided in a residential setting (i.e., therapy in Appellant's home or apartment), long-term, 24 hour per day treatment in a non-institutional residential setting is not a Medicaid covered service. As such, [redacted] is neither allowed nor obligated to authorize this service, rendering appropriate its denial in this matter.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide that [redacted] denial of Appellant's request for long-term residential placement is proper.

IT IS THEREFORE ORDERED that:

[redacted] decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 9/2/2009

***** 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.