STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

[redacted],
Appellant

_____/

Docket No. 2010-25110 CMH
[redacted]

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. Her witness was [redacted], hearings coordinator, represented the Department. Her witness was [redacted] Vice President of Medical Affairs. Also in attendance were [redacted] case manager and [redacted]

PRELIMINARY MATTER

At hearing the Appellant offered her proposed exhibit #2 – a compilation of physical medical history - the admission of which was taken under advisement by the ALJ. On review the document was admitted, but afforded little weight for lack of relevance.

ISSUE

Did the department properly deny psychiatric inpatient hospitalization for the Appellant on [redacted]

FINDINGS OF FACT

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

1. The Appellant is a [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with DM, anorexia nervosa, bulimia nervosa major depressive disorder (recurrent) without psychosis. (Department's Exhibit A, p. 8)

3. On [redacted] a crisis screening was completed during the Appellant's stay in the medical unit of the [redacted]. (Department's Exhibit A, pp. 1 – 14 and See Testimony of [redacted]

4. The Appellant was denied hospitalization in the psychiatric unit for lack of medical necessity. (See Department's Exhibit A, pp. 1 – 14 and See Testimony of [redacted])

5. On [redacted], the Department advised the Appellant, by adequate action notice, that her requested service (inpatient hospitalization in the psychiatric unit) was denied for failure to meet medical necessity for inpatient services. (Department's Exhibit A, pp. 15-17

6. The Appellant's further appeal rights and instructions were included therein. (Department's Exhibit A, pp. 15-17)

7. The instant request for hearing was received by SOAHR on [redacted] (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> 42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> 42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. Genesee County Community Mental Health (GCCMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by the CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See* 42 CFR 440.230

As a person afflicted with a serious mental illness the Appellant is entitled to receive services from the CMH. *See* Medicaid Provider Manual, (MPM) Mental Health [ ], Beneficiary Eligibility, §1.6, April 1, 2010, page 3 and MCL 330.1100d(3)

However, the construction of those services and supports are not static, but rather subject to review by mental health professionals confirming that a current functional impairment and a current medical necessity exists for those specialized services and supports which require inpatient psychiatric treatment:

APPEALS

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

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ELIGIBILITY CRITERIA [INPATIENT PSYCHIATRIC]

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 <u>whether the beneficiary's immediate treatment needs are primarily medical or psychiatric</u>. 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.

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INPATIENT ADMISSION CRITERIA [ ]

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 [ ] 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 reinitiation 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.

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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.

(Emphasis supplied) Medicaid Provider Manual, (MPM) Mental Health [ ] §§8 *et seq* Inpatient Psychiatric Hospital Admissions, April 1, 2010, pp. 42 - 48

[ ] MEDICAL NECESSITY CRITERIA

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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.

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Using criteria for medical necessity, a PHIP may:

- 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.
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> MPM, *Supra*, pp.12-14

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The Department witness, [redacted], testified that as the medical director/chief psychiatrist for the PHIP he is the final authority in [redacted] for inpatient psychiatric hospital admission.

He added that he personally reviewed the Appellant's crisis report and engaged in several telephone calls with other medical professionals at the [redacted]. He said that the [redacted] was in agreement with his opinion that the least restrictive course of action was in the Appellant's best interest. [redacted] referred the Appellant back to her primary program for continued long term referral to high risk case management, DBT and nurse consultation.

The Appellant's representative and her witness testified that the outpatient course of action was not working. She offered the opinion of [redacted] who opined that the Appellant is not medically able to care for herself. See Appellant's Exhibit #3

The Appellant's representative said "no one is concerned about her weight."

[redacted] concluded his testimony stating that he was "…not suggesting that the Appellant did not have a multitude of problems, but that her best course of action was to avoid psychiatric unit living [ ]."

On review, it is clear that the Department did not arbitrarily deny the Appellant's request for inpatient psychiatric hospitalization, but rather determined that such a service was not medically necessary following an extensive procedural review - as required under the MPM in addition to significant peer consultation between the hospital and the PHIP.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied the Appellant's request for inpatient psychiatric hospitalization.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/7/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.