STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 14-010059 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon the Appellant's request for a hearing.

After due notice, a hearing was held on October 16, 2014. Appellant appeared and testified on his own behalf. [redacted] Fair Hearings Officer, represented Respondent Network 180. [redacted], Access Center Clinician, testified as a witness for Respondent.

ISSUE

Did Network 180 properly deny Appellant's request for inpatient psychiatric and partial hospitalization services?

FINDINGS OF FACT

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

1. Network 180 is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in its service area.

2. Appellant is a [redacted] year-old male who has been diagnosed with major depressive disorder; attention deficit hyperactivity disorder; adjustment disorder with depressed mood; and personality disorder NOS. (Petitioner's Exhibit 1, page 1; Respondent's Exhibit D, page 1).

3. Appellant is enrolled with a Medicaid Health Plan (MHP), Priority Health, and saw an outpatient therapist there three times. (Petitioner's Exhibit 1, page 1; Respondent's Exhibit C, page 1).

4. That outpatient therapist then began working to schedule Appellant with a psychiatrist through Priority Health and also recommended that Appellant receive for inpatient psychiatric and partial hospitalization services through Network 180. (Petitioner's Exhibit 1, page 1; Respondent's Exhibit C, page 1).

5. On August 21, 2014, [redacted] conducted a screening with Appellant and assessed the request for services. (Respondent's Exhibit C, pages 1-10).

6. During that screening and assessment, [redacted] noted that Appellant's outpatient therapist had referred him for inpatient psychiatric and partial hospitalization services because Appellant was experiencing symptoms of major depressive disorder and complained of difficulties maintaining employment and problems with significant relationships. (Respondent's Exhibit C, page 1).

7. Appellant also reported staying up all night to make an appointment with his therapist that morning and that he sometimes struggles with self-care or remembering to eat. (Respondent's Exhibit C, pages 1, 3).

8. [redacted] further noted that Appellant was a willing participant in the assessment process, did not exhibit any current risk factors, and did not have any suicidal or homicidal ideations. (Respondent's Exhibit C, pages 1, 4, 6-7).

9. Accordingly, [redacted] determined that Appellant did not meet the criteria for the requested services and he advised Appellant to return to his therapist and have a psychiatric appointment scheduled, and to look into psychological testing with Michigan Works!. (Respondent's Exhibit C, pages 4-5).

10. [redacted] also gave Appellant written notice that Appellant's request for inpatient psychiatric and partial hospitalization services was denied because he did not present with any critical or acute symptoms. (Respondent's Exhibit C, pages 9-10).

11. On or about August 25, 2014, Appellant filed a local appeal with Network 180 regarding the denial of his request for services. (Respondent's Exhibit D, pages 1-2).

12. [redacted], MSW and LMSW, then met with Appellant and reviewed Appellant's symptoms, clinical history, risk factors, and current treatment. (Respondent's Exhibit D, pages 1-2).

13. During that review, Hulce noted that Appellant had an appointment with a psychiatrist scheduled for October 16, 2014. (Respondent's Exhibit D, page 2).

14. [redacted] also determined that Appellant did not meet the criteria for inpatient psychiatric and partial hospitalization services in either risk or acuity, while also advising Appellant that he could be reassessed if there was a crisis and/or Appellant's condition or risk factors became more severe. (Respondent's Exhibit D, page 2).

15. On September 5, 2014, Network 180 sent Appellant written notice that the local appeal had upheld the earlier denial of his request for partial hospitalization services. (Respondent's Exhibit E, page 1).

16. On August 28, 2014, the Michigan Administrative Hearing System (MAHS) received Appellant's request for hearing in this matter. (Respondent's Exhibit B, page 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*

Additionally,

> 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 also provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be approved by Network 180 pursuant to that waiver are inpatient psychiatric and partial hospitalization services, and, with respect to those covered services, the applicable version of the Medicaid Provider Manual (MPM) states:

> **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 coexist 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.B. INPATIENT ADMISSION CRITERIA: ADULTS

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon 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, 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.

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

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 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 that 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.

	▪ 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 serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational / occupational role performance expectations. ▪ Harm to Self ➢ Suicide: Attempt or ideation is considered serious by the intention, 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. ▪ 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. ▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ➢ 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 coexisting 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 or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, 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 necessary due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed 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.

MPM, July 1, 2014 version
Mental Health/Substance Abuse Chapter, pages 47, 49-52

Here, Network 180 found that Appellant did not meet the above criteria for services and it denied Appellant's request for inpatient psychiatric and partial hospitalization services.

Appellant challenges that decision on appeal and, in doing so, bears the burden of proving by a preponderance of the evidence that Network 180 erred in denying his request. Moreover, the undersigned Administrative Law Judge's jurisdiction is limited to reviewing Network 180's decision in light of the information available at the time that decision was made.

Given the record in this case and the applicable policies, Appellant has failed to meet his burden of proof and Network 180's decision must be affirmed. The criteria identified above for the requested service includes requirements relating to both severity of illness and intensity of services. However, in this case, Appellant does not meet the requirements in either area.

For example, while Appellant presented with symptoms of depression, nothing indicates that he had severe psychiatric signs and symptoms; any serious disruption in self-care and independent functioning; any danger of self-harm; any danger of harm to others; or any drug/medication complications or coexisting general medical condition requiring care. At most, the evidence suggested that Appellant has some difficulties with employment, significant relationships and self-care; and there is nothing to support Appellant's assertion that the severity of his illness rises to the level required by the above policy.

Similarly, while Appellant is clearly in need of some treatment, nothing in the record suggests that close and continuous skilled medical observation and supervision are necessary. At the time of his request, Appellant's symptoms were not that severe and he had only seen his outpatient therapist three times. He and his outpatient therapist were also in the process of scheduling an appointment with a psychiatrist.

To the extent Appellant's circumstances change, his symptoms become more severe and he requires a greater intensity of service, he can always re-request the inpatient psychiatric and partial hospitalization services. Moreover, Appellant could also request

other services through Network 180 that do not have such rigorous requirements. With respect to the only decision at issue in this case however, Network 180's decision must be affirmed for the reasons discussed above.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Network 180 properly denied Appellant's request for inpatient psychiatric and partial hospitalization services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven J. Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: October 31, 2014

Date Mailed: October 31, 2014

SK/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.