

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 2014-25527 CMH

██████████,

██████████

Appellant

_____ /

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, an in-person hearing was held on ██████████ and ██████████, parents, represented the Appellant.

██████████, Utilization Manager, represented ██████████ (CMH or Department). ██████████ Supervisor for ██████████, appeared as a witness for the Department. ██████████, Chief Operating Officer, and ██████████, Case Manager, were present as observers.

ISSUE

Did the CMH properly deny the Appellant's request for a Secure Sleep System- Beds by George- SS 170?

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 █-year-old Medicaid beneficiary who has been receiving services through the CMH.
2. The CMH is under contract with the Michigan Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.
3. The Appellant has been diagnosed with Autism and ADHD.
4. The CMH received a request for a Secure Sleep System - Beds by George - SS 170 for the Appellant.

5. The Department determined that the Appellant's request for the enclosed specialty bed system must be denied because the bed system is considered restrictive and could result in a form of restraint and/or seclusion not allowed by the Mental Health Code.
6. On ██████████, an Action Notice and Hearing Rights was issued to the Appellant regarding the denial of the enclosed specialty bed system.
7. On ██████████ the Michigan Administrative Hearing System received Appellant's request for hearing.

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

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.*

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria, be appropriate to the individual's needs, and meet the standards herein. *Medicaid Provider Manual, Mental Health and Substance Abuse Section, October 1, 2013, Page 4.*

Medical necessity is defined by the Medicaid Provider Manual 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.

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;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP 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

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- 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.

*Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2013, Pages 12-14*

The program requirements set forth in the Medicaid Provider Manual for Mental health and developmental disabilities services (state plan, HSW, and additional/B3) includes:

Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

*Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2013, Page 8*

Regarding Goals that meet the intents and purpose of B3 Supports and Services, the Medicaid provider manual states:

However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned.

*Medicaid Provider Manual,
Mental Health and Substance Abuse Section,
October 1, 2013, Page 111*

The Mental Health Code addresses suitable services, treatment environment, setting and rights:

- (1) A recipient shall receive mental health services suited to his or her condition.
- (2) Mental health services shall be provided in a safe, sanitary, and humane treatment environment.
- (3) Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- (4) A recipient has the right to be treated with dignity and respect.

MCL 330.1708

The Mental Health Code defines restraint and seclusion:

- (i) "Restraint" means the use of a physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.
- (j) "Seclusion" means the temporary placement of a recipient in a room, alone, where egress is prevented by any means.

MCL 330.1700

The Mental Health Code addresses physical restraint:

- (1) A resident shall not be placed in physical restraint except in the circumstances and under the conditions set forth in this section or in other law.
- (2) A resident may be restrained only as provided in subsection (3), (4), or (5) after less restrictive interventions have been considered, and only if restraint is essential in order to prevent the resident from physically harming himself, herself, or others, or in order to prevent him or her from causing substantial property damage. Consideration of less restrictive measures shall be documented in the medical record. If restraint is essential in order to prevent the resident from physically harming himself, herself, or others, the resident may be physically held with no more force than is necessary to limit the resident's movement, until a restraint may be applied.
- (3) A resident may be temporarily restrained for a maximum of 30 minutes without an order or authorization in an emergency. Immediately after imposition of the temporary

restraint, a physician shall be contacted. If, after being contacted, the physician does not order or authorize the restraint, the restraint shall be removed.

(4) A resident may be restrained prior to examination pursuant to an authorization by a physician. An authorized restraint may continue only until a physician can personally examine the resident or for 2 hours, whichever is less. If it is not possible for the physician to examine the resident within 2 hours, a physician may reauthorize the restraint for another 2 hours. Authorized restraint may not continue for more than 4 hours.

(5) A resident may be restrained pursuant to an order by a physician made after personal examination of the resident. An ordered restraint shall continue only for that period of time specified in the order or for 8 hours, whichever is less.

(6) A restrained resident shall continue to receive food, shall be kept in sanitary conditions, shall be clothed or otherwise covered, shall be given access to toilet facilities, and shall be given the opportunity to sit or lie down.

(7) Restraints shall be removed every 2 hours for not less than 15 minutes unless medically contraindicated or whenever they are no longer essential in order to achieve the objective which justified their initial application.

(8) Each instance of restraint requires full justification for its application, and the results of each periodic examination shall be placed promptly in the record of the resident.

(9) If a resident is restrained repeatedly, the resident's individual plan of services shall be reviewed and modified to facilitate the reduction of the use of restraints.

MCL 330.1740

The Mental Health Code also addresses seclusion:

(1) Seclusion shall be used only in a hospital, a center, or a child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128. A resident placed in a hospital or center shall not be kept in seclusion except in the circumstances and under the conditions set forth in this section.

(2) A minor placed in a child caring institution shall not be placed or kept in seclusion except as provided in 1973 PA 116, MCL 722.111 to 722.128, or rules promulgated under that act.

(3) A resident may be placed in seclusion only as provided under subsection (4), (5), or (6) and only if it is essential in order to prevent the resident from physically harming others, or in order to prevent the resident from causing substantial property damage.

(4) Seclusion may be temporarily employed for a maximum of 30 minutes in an emergency without an authorization or an order. Immediately after the resident is placed in temporary seclusion, a physician shall be contacted. If, after being contacted, the physician does not authorize or order the seclusion, the resident shall be removed from seclusion.

(5) A resident may be placed in seclusion under an authorization by a physician. Authorized seclusion shall continue only until a physician can personally examine the resident or for 1 hour, whichever is less.

(6) A resident may be placed in seclusion under an order of a physician made after personal examination of the resident to determine if the ordered seclusion poses an undue health risk to the resident. Ordered seclusion shall continue only for that period of time specified in the order or for 8 hours, whichever is less. An order for a minor shall continue for a maximum of 4 hours.

(7) A secluded resident shall continue to receive food, shall remain clothed unless his or her actions make it impractical or inadvisable, shall be kept in sanitary conditions, and shall be provided a bed or similar piece of furniture unless his or her actions make it impractical or inadvisable.

(8) A secluded resident shall be released from seclusion whenever the circumstance that justified its use ceases to exist.

(9) Each instance of seclusion requires full justification for its use, and the results of each periodic examination shall be placed promptly in the record of the resident.

(10) If a resident is secluded repeatedly, the resident's individual plan of services shall be reviewed and modified to facilitate the reduced use of seclusion.

MCL 330.1742

The Mental Health Code also addresses Freedom of Movement:

(1) The freedom of movement of a recipient shall not be restricted more than is necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage, except that security precautions appropriate to the condition and circumstances of an individual admitted by order of a criminal court or transferred as a sentence-serving convict from a penal institution may be taken.

(2) A restriction adopted under the authority of subsection (1), the date it expires, and justification for its adoption shall be promptly noted in the record of the recipient.

(3) A restriction adopted under the authority of subsection (1) shall be removed when the circumstance that justified its adoption ceases to exist.

MCL 330.1742

In this case, the CMH consulted with the State regarding the request for a Secure Sleep System - Beds by George - SS 170 for the Appellant. The requested bed system has three wooden sides and a wooden door on the fourth side extending well above the mattress. There is also a mesh safety enclosure for the top. (Exhibit 5, pages 1-2) It was uncontested that once secured inside, this bed system would fully enclose the Appellant and it can only be opened from the outside.

The Appellant's parents testified their intent was to use the enclosed bed system at night to ensure the Appellant's safety. The Appellant has no safety awareness and severely limited cognitive ability. They compared the use of the requested bed to the use of a seat belt in a car. The Appellant tends to try to open any window or door, climbs chairs, counters, or couches and would leave a room or even the home if he is not carefully watched. In the winter, the Appellant could end up outside without appropriate clothing for the weather. The Appellant's mother also noted the home is on a busy street and very close to a lake. There is a very understandable concern that the Appellant would be at risk of harm to himself from wandering if he gets out overnight. Previously, the Appellant slept in a crib with netting over the top. (Parent's Testimony and Exhibit 3, page 4)

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As described the Appellant would be placed in the requested enclosed bed system to prevent egress during the night. While the testimony of the Appellant's parents indicates the Appellant has sibling(s) that share the same bedroom, the Appellant would still be alone in the enclosed bed system and unable to leave until someone else opened the door from the outside. The email response from the State indicates that use of this type of bed is considered as seclusion and Medicaid money cannot be used for this type of enclosure. (Exhibit A, page 5) As cited above, MCL 330.1742(1) only allows for seclusion to be used in a licensed hospital, a center, or a child caring institution and only in specified circumstances and conditions.

The CMH also asserts this type of bed is considered restrictive and could result in a form of restraint not allowed by the Mental Health Code. The enclosed bed system is a physical device that would restrict Appellant's movement as the Appellant could only get out of the bed system to move about freely when it is opened from the outside by someone else. MCL 330.1740 only allows for physical restraint in specified circumstances and conditions. MCL 330.1744 further directs that the freedom of movement of a recipient shall not be restricted more than is necessary.

The CMH also asserted that the Medicaid Provider Manual policy does not appear to allow for the purchase of a bed of any kind as a B-3 waiver support or service. Medicaid Provider Manual, Mental Health/Substance Abuse, 17.3 B3 Supports and Services, October 1, 2013, pages 112-136. It is noted that the policy addressing Assistive Technology specifically excludes coverage of "furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home." Medicaid Provider Manual, Mental Health/Substance Abuse, 17.3A Assistive Technology, October 1, 2013, page 113. It is not clear that this portion of the Medicaid Provider Manual policy would exclude coverage for a specialty and/or custom bed system because this is not an item that would routinely be found in a home. However, the other requirements and prohibitions found in the Medicaid Provider Manual and the Mental Health Code would still apply.

While this ALJ understands the Appellant's parent's intent is to keep the Appellant safe at night, the very restrictive and secluding nature of the requested enclosed bed system cannot be overlooked. The Mental Health Code and Medicaid Provider Manual citations above repeatedly emphasize that supports and services should be provided in the least restrictive manner. Even the [REDACTED] letter from the Appellant's doctor requesting a safety sleep system for the Appellant's personal protection notes it is important that the parents know when the Appellant is trying to get out of bed. (Exhibit 3, page 1) The requested enclosed bed system would not alert the Appellant's parents when the Appellant is trying to get out of bed. Rather, the Appellant would simply be prevented from leaving the confines of the enclosed bed system. Additionally, the [REDACTED] letter from the occupation therapist indicates the Appellant is in need of more one on one care. (Exhibit 3, page 4)

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The CMH has offered alternatives addressing the concern for the Appellant's safety overnight. Options included a door alarm system for the bedroom and baby monitoring system that could include video. Additionally, it was uncontested that the CMH has developed and implemented a plan to work on the Appellant's sleep behavior that includes staff being present overnight. The Appellant's parents asserted the Appellant has still had some scrapes and bruises even with the CMH staff present overnight. The Appellant's parents also testified that the staff presence overnight has interfered with the Appellant's sleep, as well as the sleep of others in the home. However, under the Mental Health Code and Medicaid Provider Manual policy it was appropriate for the CMH to suggest and/or authorize less restrictive supports and services for the Appellant.

The Appellant bears the burden of proving by a preponderance of the evidence that the CMH determination to deny the Secure Sleep System - Beds by George - SS 170 was incorrect. Here, the Appellant did not prove by a preponderance of the evidence that the requested bed would not be considered a prohibited restraint or seclusion under the Mental Health Code. It is uncontested that the requested bed would enclose fully the Appellant overnight and can only be opened by someone else from outside. Further, not all alternative less restrictive supports and services had been ruled out or demonstrated to be unsuccessful for the Appellant. Based on the information available at that time, the denial of the requested Secure Sleep System - Beds by George - SS 170 was appropriate. Accordingly, the CMH's determination must be upheld.

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 a Secure Sleep System- Beds by George- SS 170 based on the available information.

IT IS THEREFORE ORDERED that:


The CMH decision is AFFIRMED.

/s/

Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]


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***** 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.