[redacted]
MI [redacted]

Date Mailed: February 4, 2020
MOAHR Docket No.: 19-011927
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 *et seq*; 42 CFR 438.400 *et seq*; and Mich Admin Code, R 792.11002.

After due notice, a hearing was held on December 3, 2019. [redacted] Father and Guardian, appeared on behalf of the Petitioner. [redacted] mother, appeared as a witness for Petitioner. From the University of Michigan, Cassie Sweidan, Advanced Care Management Team Program Manager; and Amy Rosinski, Attending Psychiatrist appeared as witnesses for Petitioner. Ashlee Kind, Customer Service Specialist, NorthCare Network, the Prepaid Inpatient Health Plan (PIHP), represented the Respondent. From Copper Country Community Mental Health (CCCMH), Leslie Griffith, Outpatient Program Director; Sarah Rousseau, Recipient Rights Officer; Kim Ison, Recipient Rights Advisor; Cari Raboin, Executive Director; and Mike Bach, Associate Director; appeared as witnesses for Respondent. From NorthCare Network, Brittany Pietsch, Clinical Practices Coordinator; Katreena Hite, Integrated Care Specialist; and Dr. Vasilis K. Pozios, Medical Director, appeared as witnesses for Respondent.

During the hearing proceeding, Respondent's Hearing Summary packet was admitted as Exhibit A, pp. 1-38, the Hearing Request was admitted as Exhibit 1, pp. 1-10.

ISSUE

Did Respondent properly deny requests for inpatient psychiatric admission and residential eating disorder treatment for Petitioner?

FINDINGS OF FACT

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

1. Petitioner is a [redacted]-year-old Medicaid beneficiary, date of birth [redacted] 1977. (Exhibit 1, p. 2)

2. Petitioner has a history of Chron's disease, gastric ulcer perforation, depression, anxiety symptoms consistent with the diagnosis of obsessive compulsive disorder, and disordered eating consistent with the diagnosis of avoidant/restrictive food intake disorder. Petitioner also exhibits maladaptive personality traits (primarily schizoid, borderline, and narcissistic) as well as possible signs and symptoms of Autism Spectrum Disorder. Malnutrition, colitis, and psychogenic polydipsia with hyponatremia have also been noted. (Exhibit A, p. 5; Exhibit 1, p. 3)

3. Petitioner was admitted to [redacted] in [redacted] on or about May 24, 2019, where the perforated gastric ulcer was repaired. During this hospitalization, Petitioner was found to be severely malnourished and was started on total parenteral nutrition (TPN) followed by tube feeds. Petitioner is 6 feet tall and was down to 112 pounds. (Exhibit A, pp. 1 and 4)

4. During that hospitalization, Petitioner's Medicaid health plan, Upper Peninsula Health Plan (UPHP) had been coordinating with CCCMH regarding discharge and after care planning. This included pre-screening from CCCMH with an outcome of diversion due to hospitals being unwilling to take someone for eating disorders and on NJ tubes. Parties attempted to find eating disorder treatment in a structured setting. [redacted] also attempted to find a skilled nursing facility placement. Outpatient follow-up care was planned with Dr. Trusock on June 18, 2019. (Exhibit A, p. 1)

5. Petitioner left [redacted] against medical advice on June 7, 2019. (Exhibit A, pp. 1 and 4)

6. Petitioner had an emergency Department visit on June 17, 2019, and was released after a few hours. (Exhibit A, p. 1)

7. On June 18, 2019, Petitioner saw Dr. Trusock for an outpatient visit and it was recommended that Petitioner seek care at [redacted]. (Exhibit A, p. 1)

8. On June 19, 2019, Petitioner was seen in the emergency room and was transferred to [redacted] ([redacted]) on June 20, 2019, due to wound dehiscence. Petitioner also had a dangerously low body mass index (BMI) of 14.95. (Exhibit A, pp. 1 and 4)

9. On July 3, 2019, [redacted] contacted UPHP requesting prior authorization for an out of state residential eating disorder clinic. UPHP advised that they do not have eating disorder treatment as a Medicaid covered service and directed [redacted] to contact NorthCare. (Exhibit A, p. 1)

10. On July 3, 2019, NorthCare emailed Michigan Department of Health and Human Services (MDHHS) with questions regarding treatment and payment for eating disorder treatment. The email indicates it would not be medically necessary for the individual to be admitted to a medical hospital and would not necessarily need an inpatient psychiatric hospital in the typical sense. Treatment would be at an eating disorder clinic. (Exhibit A, pp. 1-2)

11. On July 24, 2019, [redacted] contacted UPHP noting that Petitioner was nearly medically stable, but continuing with TPN at that time. (Exhibit A, p. 2)

12. On July 24, 2019, [redacted] inquired with CCCMH about an eating disorder program and were informed that due to having Michigan Medicaid, Petitioner would need to go to a Michigan hospital. (Exhibit A, p. 2)

13. On July 30, 2019, CCCMH noted that the only inpatient psychiatric hospital in Michigan that addresses eating disorders is Forest View, but they denied Petitioner admittance due to having a feeding tube. St. Mary's, a hospital that takes more medically complex cases, also denied admittance for this reason. [redacted] suggested treatment in Denver, Co. CCCMH stated that treatment in Wisconsin may be an option, but they do not specialize in eating disorder. (Exhibit A, p. 2)

14. On August 1, 2019, UPHP contacted NorthCare Network regarding concerns from their contact with [redacted]. [redacted] was attempting to find inpatient psychiatric hospitalization for Petitioner due to anorexia and had been working with CCCMH, who advised they would only place Petitioner in a hospital bed in Michigan. (Exhibit A, p. 2)

15. On August 6, 2019, MDHHS responded to the July 3, 2019 email from NorthCare:

> Wanted to let you know that I have had staff checking into your question about eating disorders. If the PIHP determines that the individual meets the criteria to be served with the specialty behavioral health benefit, you would be able to cover the services that you determine to be medically necessary. An eating disorder diagnosis by itself really does not meet the definition of a serious mental illness so the overall functioning level and any co-occurring conditions would need to be considered.
>
> We also agree that our provider manual has very little information on eating disorders and we will try to work with the Medical Services Administration to improve this.
>
> (Exhibit A, p. 2)
> Underline added by ALJ

16. On August 6, 2019, an ongoing email from NorthCare to MDHHS indicates the medical unit was insisting that the individual not go home and instead go

to an eating disorder clinic in Denver or New York. MDHHS responded that the PIHP would not be responsible to cover the out of state clinic, the most they could find on coverage would be for outpatient services. MDHHS also indicated there used to be some eating disorder programs in Michigan but did not know if they still existed. MDHHS suggested [redacted] as a place to start. (Exhibit A, pp. 2-3, underline added by ALJ)

17. On August 7, 2019, the NorthCare Medical Director discussed the case with the [redacted] consult psychiatrist. (Exhibit A, p. 3)

18. On August 10, 2019, the NorthCare Medical Director indicated: inpatient eating disorder treatment is medically necessary for Petitioner; adult eating disorder treatment is not a covered behavioral health service; adult eating disorders may be considered a serious medical condition and therefore be covered by the Medicaid health plan. (Exhibit A, p. 3)

19. On August 14, 2019, it was clarified that NorthCare's Medical Director's opinion was that the treatment Petitioner required should be provided at an inpatient eating disorder facility as it requires medical interventions, including feeding tube management. An inpatient psychiatric unit would not be able to accommodate the needs of this medically complex patient. (Exhibit A, p. 3)

20. On August 28, 2019, MDHHS indicated they received information from Medical Services Administration (MSA) and UPHP about Petitioner, presumably the case for the prior inquiries were made about. MDHHS asked about a formal assessment for inpatient psychiatric hospitalization for Petitioner as they would like to review the information as well. (Exhibit A, p. 4)

21. On September 2, 2019, NorthCare informed UPHP that they had reached out to MDHHS and treatment for anorexia is not a covered benefit under the Medicaid behavioral health section. (Exhibit A, p. 4)

22. On September 6, 2019, NorthCare's Medical Director met with Petitioner recommended residential eating disorder treatment. (Exhibit A, p. 4)

23. On September 11, 2019, NorthCare's Medical Director provided a clinical write up, concluding "Given the severity of [Petitioner's] disordered eating, the potentially life-threatening medical complications of malnutrition and eating disorder behaviors, and his severe lack of insight into his disordered eating, it is my opinion that specialized treatment at a residential eating disorder program is medically necessary for [Petitioner]. (Exhibit A, pp. 4-6)

24. On September 23, 2019, a team consult meeting occurred with NorthCare, [redacted], CCCMH, and UPHP. (Exhibit A, pp. 6-7)

25. On September 23, 2019, a Notice of Adverse Benefit Determination was issued to Petitioner denying inpatient hospitalization stating:

> Following preadmission screening completed by Dr. Pozios from [NorthCare] on 9.6.19, the Medicaid Medical Necessity Criteria for inpatient psychiatric treatment is not met and not recommended at this time. Staff from [redacted, UPHP, NorthCare, and CCCMH] had an integrated care coordination meeting regarding your case to ensure that you receive the treatment you need in the least restrictive environment possible. We are seeking clarification from MDHHS regarding options for your treatment.
>
> (Exhibit A, p. 9)

26. On September 23, 2019, a Notice of Adverse Benefit Determination was issued to Petitioner denying residential eating disorders treatment stating:

> Residential Eating Disorder treatment is not a Medicaid covered service, Medicaid Provider Manual, Behavioral Health Section.
>
> (Exhibit A, p. 15)

27. On September 24, 2019, the PIHP had a conversation with MDHHS and again it was confirmed that residential eating disorder treatment is not a Medicaid covered service. (Exhibit A, p. 7)

28. On October 1, 2019, appeals were filed on Petitioner's behalf regarding the denials for inpatient psychiatric admission and residential eating disorder treatment. (Exhibit A, p. 7)

29. On October 2, 2019, the appeal information was sent to an Independent Review Organization (IRO). (Exhibit A, p. 7)

30. On October 4, 2019, the IRO review report was completed. The findings/opinion were:

    1. The patient has been stabilized medically since admitting to the facility with low body weight, infection, and issued related to past abdominal surgery. There is no indication that he remains at dangerously low body weight requiring treatment in an inpatient psychiatric/eating disorder treatment level of care. The patient has been medically stabilized and cleared for transition from medical treatment.

    2. The patient reports a history of some passive suicidal ideation. However, he is not actively suicidal with intent or plan, homicidal, acutely psychotic, or gravely disabled.

3. The patient attributes his eating to his underlying medical issues including Crohn's disease. The patient's father is his temporary guardian.

4. In the opinion of this reviewer, the patient does not meet Michigan Medicaid Provider Manual for treatment at the inpatient psychiatric hospitalization level of care as requested. Consideration should be given to treatment in the partial hospitalization level of care in addition to ongoing medical care as needed.

(Exhibit A, pp. 26-27)

31. On October 15 and 17, 2019, Hawthorne Center completed a psychological consultation to evaluate whether Petitioner meets criteria for Autism Spectrum Disorder (ASD). Petitioner's score on the ADOS-2 met cut off for Autism requiring substantial support. In part, the assessment results indicated Petitioner met criteria for a diagnosis of ASD, and suggested he met criteria for a diagnosis of Avoidant/Restrictive Food Intake Disorder. The recommendations were:

    1. In order to ensure a comprehensive and cohesive delivery of services, communication and collaboration between home and outpatient services should occur regularly. Additionally, [Petitioner's] caregivers should work closely with individuals treating him (e.g., therapist, psychiatrist, and in-home staff). Community mental health services would likely be beneficial to help coordinate care across multiple settings in order to provide comprehensive support to [Petitioner]. These services often include home-based interventions, as well as staffing in the home to support and implement behavioral plans. Group therapy may also be helpful. Community Living Services, if available, would also be beneficial to [Petitioner] to help foster community engagement and increase adaptive skills.

    2. It is recommended that [Petitioner] remain under the care of a psychiatrist to assist with medication management. Medication management can target the mood symptoms which have led to an increase in problematic behavior patterns. Medication adjustments can further support [Petitioner's] amenability to the interventions needed to improve his coping skills.

    3. [Petitioner] should receive continued support to scaffold his independent living skills and monitor his functioning, treatment, and continued progress. Specifically, he requires assistance with financial planning, social engagement, and meal and eating routines.

(Exhibit A, pp. 36-38)

32. On October 31, 2019, NorthCare issued a Notice of Appeal Denial regarding the inpatient psychiatric admission indicating that after review of records provided by [redacted] it was determined that Petitioner was medically stable, at an appropriate body weight, denying suicidal or homicidal ideation, and was not experiencing psychosis. Therefore, medical necessity criteria was not met for admission to an inpatient psychiatric hospital. Further assessment from additional parties indicated recommendations of outpatient services through Community Mental Health. (Exhibit A, p. 20)

33. On October 31, 2019, NorthCare issued a Notice of Appeal Denial regarding the residential eating disorder treatment stating residential eating disorders treatment is not a covered benefit under Michigan Medicaid referencing the Medicaid Provider Manual and communications with MDHHS. Additionally, it was noted that further assessment from additional parties indicated recommendations of outpatient services through Community Mental Health. (Exhibit A, p. 23)

34. On November 14, 2019, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing seeking eating disorder treatment funding. (Exhibit 1, pp. 1-10)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…
>
> *42 USC 1396(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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the Medicaid Provider Manual (MPM) states:

> **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;
  - that are 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.

MPM, July 1, 2019 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services
Pages 14-15

Regarding location of services, the MPM states:

2.3 LOCATION OF SERVICE

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary

service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

MPM, July 1, 2019 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
Page 10

Inpatient psychiatric hospitalization is a Medicaid covered behavioral health service. The 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.

***

Admission to Out-of- State Non- Borderland Inpatient Psychiatric Hospitals

The PIHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PIHP is responsible for continued stay reviews and payment to these hospitals.

***

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.

***

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 or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-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).

- Drug/Medication Complications or Coexisting General Medical Condition Requiring Care
  - There has been significant destructive behavior toward property that endangers others.
  - 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.

***

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, 2019 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services
Pages 57-62
Underline added by ALJ

No provisions in the MPM could be found that specifically address residential eating disorder treatment.

The parties also addressed the potential of the Medicaid Health Plan (MHP) covering the requested residential eating disorder treatment. Relevant potions of the MHP chapter of the MPM are noted, however, jurisdiction for this appeal is limited to reviewing the PIHP's determination.

1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID

The following Medicaid services are not covered by MHPs:

***

- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)

- Mental health services outside the MHP's contractual responsibility

- Outpatient partial hospitalization psychiatric care

MPM, July 1, 2019 version
Medicaid Health Plans
Pages 2-3
(portions of list omitted by ALJ)

2.7 MENTAL HEALTH

MHPs are required to provide behavioral health services under the Mental Health Outpatient benefit, consistent with the policies and procedures established by Medicaid. Services may be provided through contracts with Prepaid Inpatient Health Plans (PIHP) and/or Community Mental Health Services Programs (CMHSP) or through contracts with other appropriate providers within the service area. For mental health needs that do not meet Medicaid's established criteria, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.

MPM, July 1, 2019 version
Medicaid Health Plans
Page 8

It noted that there are refences to CCCMH only potentially covering inpatient psychiatric treatment in a Michigan hospital bed. (Exhibit A, p. 2) However, the above cited MPM policy, Section 8. Inpatient Psychiatric Hospital Admissions, clearly allows for instances where a PIHP is responsible for a resident that they place into a community program in another state, even for non-borderland psychiatric inpatient care. Further, it is presumed that the CCCMH indication that treatment at contracted hospitals in Wisconsin may be an option was based on the Wisconsin hospitals being considered within borderland. (Exhibit A, p. 2) Accordingly, it is unclear what the references to only being able to potentially cover inpatient psychiatric treatment in a Michigan hospital bed are based on. However, ultimately it was uncontested that treatment at a typical inpatient psychiatric unit is not appropriate for Petitioner.

It is noted that initially, it appears treatment at centers in Denver or New York were being considered. (Exhibit A, p. 2) Presumably, Denver and New York are non-borderland. However, the [redacted] witnesses testified that a residential eating disorder treatment center in Ohio is willing to accept Petitioner if there is funding. (Attending Psychiatrist and Advanced Care Management Team Program Manager Testimony) It is unclear whether the Ohio facility would be considered borderland, and whether this would affect the coverage determination.

Additionally, it appears that at least some of the inquiries about coverage for residential eating disorder treatment for Petitioner indicate he has anorexia. (Exhibit A, pp. 2 and 4) However, it does not appear that Petitioner has a diagnosis of anorexia. Rather, NorthCare Network's Medical Director's summary indicates Petitioner has a history of Chron's disease, gastric ulcer perforation status-post repair, depression, anxiety symptoms consistent with the diagnosis of obsessive-compulsive disorder, and disordered eating consistent with the diagnosis of avoidant/restrictive food intake disorder. Petitioner was also noted to exhibit maladaptive personality traits (primary Schizoid, Borderline, and Narcissistic), as well as possible signs and symptoms of Autism Spectrum Disorder (ASD). Lastly, Petitioner may meet criteria for Major Depressive Disorder, however, as his depression seemed to lift with refeeding, it is possible that his distorted cognition was related to malnutrition. (Exhibit A, p. 5) The October 2019, Hawthorne Center psychological consultation indicated Petitioner met criteria for a diagnosis of ASD, and the assessment suggested he met criteria for a diagnosis of Avoidant/Restrictive Food Intake Disorder. (Exhibit A, pp. 36-38)

The [redacted] Attending Psychiatrist testified that the standard of care for patients with severe eating disorders is residential eating disorder treatment. The frustrations of being ping-ponged between the MHP and PIHP were discussed by the [redacted] witnesses. While everyone agrees this is medically necessary treatment for Petitioner, no one will pay for it. Eating disorder treatment is a gray area. While it is a DSM diagnosis, it can also be considered medical treatment. Petitioner does not need an inpatient psychiatric unit, they were just forced to look at this to try to work around to get him treatment. Inpatient psychiatric units are not eating disorder treatment facilities and do not help patients with these problems. Residential eating disorder treatment, and the associated level of care, is not available in the state of Michigan. While Petitioner is eating now and has re-gained weight, he still has a one on one sitter in his room. While the tube feeds have stopped, the feeding tube is still in place and Petitioner knows that if he does not eat/maintain his weight the tube feedings will resume. The past manipulation issues with the feeding tube and the tube feedings, as well as the ongoing struggles with monitoring Petitioner's food were described. Even with the attendant, it is still difficult to do calorie counts because Petitioner shuffles food and tries to do things with it. Petitioner has been medically stable for months, but neither [redacted] nor CCCMH have the training to teach Petitioner the needed tools to maintain his weight. (Attending Psychiatrist and Advanced Care Management Team Program Manager Testimony)

It is documented that on several occasions, the PIHP's Medical Director determined that treatment at a residential eating disorder clinic is medically necessary for Petitioner. (Exhibit A, pp. 3-6) However, based on the PIHP's understanding that Medicaid does not cover residential eating disorder treatment as a behavioral health service, they looked into other options. During the hearing, the PIHP Medical Director confirmed that residential eating disorder treatment would be medically indicated for Petitioner. If there were no question regarding whether it was a Medicaid covered service, there would be no dispute as to whether this is a medically necessary service for Petitioner. (Medical Director Testimony)

The summary from the PIHP indicates they contacted MDHHS regarding any potential coverage of residential eating disorder treatment as a Medicaid behavioral health service. On July 3, 2019, NorthCare emailed MDHHS with rather general questions. On August 6, 2019, MDHHS responded, in part stating "If the PIHP determines that the individual meets the criteria to be served with the specialty behavioral health benefit, you would be able to cover the services that you determine to be medically necessary. An eating disorder diagnosis by itself really does not meet the definition of a serious mental illness so the overall functioning level and any co-occurring conditions would need to be considered." (Exhibit A, pp. 1-2, underline added by ALJ) As the submitted excerpts from the emails continue, NorthCare indicated this would be for an out of state eating disorder clinic in Denver or New York. MDHHS then responded that the PIHP would not be responsible to cover the out of state clinic, the most they could find on coverage would be for outpatient services. (Exhibit A, pp. 1-3) However, it is not clear what MDHHS referenced to make this determination. There was no citation to the MPM, the Michigan State Plan, or other policy/legal authority. From the August 28, 2019, email excerpt, MDHHS indicated they received information from MSA and UPHP about Petitioner, presumably the case for which the prior inquiries were made about. MDHHS asked about a formal assessment for inpatient psychiatric hospitalization for Petitioner as they would like to review the information as well. (Exhibit A, p. 4) On September 24, 2019, the PIHP had a conversation with MDHHS and again it was confirmed that residential eating disorder treatment is not a Medicaid covered service. (Exhibit A, p. 7) This appears to have been a telephone contact and no references to the MPM, the Michigan State Plan, or other policy/legal authority were noted.

The [redacted] Advanced Care Management Team Program Manager indicated she was told that eating disorder treatment was an optional coverage in State Plan and Michigan did not elect to cover that option. (Advanced Care Management Team Program Manager Testimony) In review of the State Plan for Michigan, there were no provisions found where Michigan elected to or not to cover eating disorder treatment.

Given the evidence and applicable policies in this case, Petitioner has not met his burden of proof regarding the PIHP's determination to deny inpatient psychiatric admission. All of the available evidence supports that inpatient psychiatric admission is not appropriate for Petitioner.

Given the evidence and applicable policies in this case, Petitioner has met his burden of proof regarding residential eating disorder treatment services. The record indicates Respondent properly consulted MDHHS when it was not clear whether residential eating disorder treatment was a covered service. Respondent denied these services for Petitioner based on their understanding that it is not a covered Medicaid behavioral health benefit. However, no references to the MPM, the Michigan State Plan, or other policy/legal authority were noted in the documentation of the communications with MDHHS to support the conclusion that it is not covered. Further, it was uncontested that residential eating disorder treatment services are medically necessary for Petitioner.

However, no evidence has been provided regarding the treatment and services Petitioner would potentially receive at a residential eating disorder clinic. Therefore, it is difficult to know whether the services would be medical, behavioral, or most likely a combination of medical and behavioral. As such, it is difficult to determine if potential coverage would be through the PIHP or the MHP. The request for residential eating disorder treatment for Petitioner should be re-considered. It is understood that there may have been changes since the initial request, such as updates and/or more detailed documentation regarding Petitioner's functioning, as well as the change with the location of the proposed treatment facility. Further clarification from MDHHS may also be needed regarding coverage of the requested services.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that Respondent properly denied inpatient psychiatric hospitalization but improperly denied residential eating disorder treatment services for Petitioner.

IT IS THEREFORE ORDERED that:

The Respondent's decision regarding inpatient psychiatric hospitalization is AFFIRMED and Respondent's decision regarding residential eating disorder treatment is REVERSED. Respondent shall initiate re-considering the request for residential eating disorder treatment for Petitioner.

Colleen Lack

CL/dh

Colleen Lack
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.	Cari Raboin Copper Country CMH 901 W. Memorial Drive Houghton, MI 49931
DHHS -Dept Contact	Belinda Hawks Lewis Cass Building 320 S Walnut St Lansing, MI 48913
Petitioner	[redacted] MI
Authorized Hearing Rep.	[redacted] MI