[redacted]
MI [redacted]

Date Mailed: October 14, 2021
MOAHR Docket No.: 21-003854
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon a request for a hearing filed on the minor Petitioner's behalf.

After due notice, a telephone hearing was held on September 16, 2021.

[redacted] Petitioner's father, appeared and testified on Petitioner's behalf. [redacted] Petitioner's stepmother, also testified as a witness for Petitioner.

Benita Brown, Due Process Coordinator, appeared and testified on behalf of Respondent Oakland County Community Health Network (OCHN or Respondent). Jasmin White, Manager of Utilization Management and Review, and Dr. Vasilis K. Pozios, M.D. and Respondent's Chief Medical Director, also testified as witnesses for Respondent.

Respondent identified an evidence packet during the hearing, but the undersigned Administrative Law Judge had not received it. However, Petitioner's representative had previously received it, he did not object to the proposed exhibit, and the evidence was therefore admitted into the record as Exhibit A, pages 1-171. Respondent also subsequently forwarded the exhibit to the Michigan Office of Administrative Hearings and Rules (MOAHR) following the hearing.

ISSUE

Did Respondent properly deny Petitioner's request for long-term hospitalization in a State psychiatric hospital?

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 who was born addicted to multiple substances. (Exhibit A, pages 12, 126).

2. He was then placed in foster care, before being adopted by his great uncle and aunt. (Exhibit A. page 12).

3. Around age three or four, Petitioner began having behavioral issues. (Exhibit A, page 128).

4. He also started seeing a private psychiatrist at age four. (Exhibit A, page 116).

5. At age seven, Petitioner's adoptive mother passed away in front of Petitioner and he was traumatized by it. (Exhibit A, page 131).

6. Petitioner currently lives with his adoptive father, stepmother, brother and stepsisters. (Exhibit A, page 128).

7. He has also been diagnosed with Oppositional Defiant Disorder; Attention-Deficit/Hyperactivity Disorder; Disruptive Mood Dysregulation Disorder; Parent-Child Relational Problem; and High Expressed Emotion Level Within Family. (Exhibit A, pages 123, 143, 155).

8. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Respondent through the Waiver for Children with Serious Emotional Disturbance (SEDW). (Exhibit A, page 102).

9. Since 2018, Petitioner has received his services through Easterseals, an agency contracted with Respondent to serve children under the SEDW. (Exhibit A, page 116; Testimony of Respondent's representative).

10. Services authorized through Easterseals have included Medication Reviews, Home-Based Therapy, Psychiatric Services, Wrap Around Services, Respite Services, Community Living Supports (CLS), Parent Support Partner, and Youth Peer Services. (Exhibit A, page 102).

11. On December 2, 2019, the Waterford Police Department dispatched officers to Petitioner's home in response to reports that he was out of control. (Exhibit A, pages 73-75).

12. Petitioner's father subsequently took Petitioner to Common Ground, a crisis provider contracted with Respondent. (Exhibit A, pages 74-75; Testimony of Manager of Utilization Management and Review).

13. On June 17, 2020, Petitioner's father called the police requesting that Petitioner be taken to Common Ground due to mental health issues, with Petitioner stating that he wanted to put a stake through his heart. (Exhibit A, pages 70-72).

14. Petitioner's father subsequently took Petitioner to Common Ground. (Exhibit A, page 72).

15. On July 20, 2020, Petitioner's father called the police and reported that Petitioner who was recently released from the hospital, was running away from him. (Exhibit A, pages 67-69).

16. The police subsequently located Petitioner, who was crying and emotional, and it was determined that Petitioner would go back to Harbor Oaks Hospital. (Exhibit A, page 69).

17. On August 6, 2020, Petitioner's father called the police and reported that Petitioner was missing after not retuning from a run, with Petitioner subsequently located later that day. (Exhibit A, pages 61-66).

18. On September 21, 2020, Petitioner was reassessed by Easterseals. (Exhibit A, pages 126-145).

19. In summary, Easterseals found in part:

> [Petitioner] is able to read, write and has no identified speech issues. He is home-schooled. [Petitioner] is up to date on his immunizations. He currently meets with Linda Storey, PA, for medication management. [Petitioner] has been on or is currently taking the following medications: Concerta, Latuda, Seroquel, Intunive, Clonidine, Methyphenidate and Abilify.
>
> The family has used ES on call services & other community supports due to physically & verbally aggressive behavior as well as hearing him making comments about wanting to die. There have been several updates to his crisis plan over this year. [Petitioner] has been in more intensive services outside of the home in the past year including New Oakland and

> Harbor Oaks. Dad also sent [Petitioner] to boot camp. [Petitioner] and his parents are struggling with communicating with one another. They will benefit from family therapy. [Petitioner] will benefit from emotion regulation, distress tolerance & improving how he communicates with his family. Dad & [Stepmother] will benefit from continuing to work with Dee, the Parent support partner, as well as to be more open to discussions with [Petitioner] and [Petitioner] is benefitting from Youth Peer Support with [redacted] His behaviors are his way of showing that he wants interaction and support from the adults in his life. [Petitioner's father] reported his concerns: temperament, not completing schoolwork when he is supposed to, stealing and fighting w/ siblings.
>
> [Petitioner] has identifie[d] losses & traumatic events in his life which indicates he is willing to further learn how to cope with his emotions related to these events. [Petitioner] has reported the following traumatic events: Loss of adoptive mother, witnessed an adult sister being threatened by her boyfriend, observe his dad & stepmom have intense arguments and lost an aunt in a car accident which also put his GM Mary in the hospital. He also experienced losses of others who were connected to his family throughout this past year. [Petitioner] and his family would benefit from [Trauma-Focused Cognitive Behavioral Therapy (TFCBT)] if they can make the weekly commitment.
>
> [Petitioner] is at the action stage of change according to his parents and his CAFAS score is 120.
>
> *Exhibit A, page 144*

20. Petitioner also underwent a Psychiatric Evaluation with Easterseals in October of 2020. (Exhibit A, pages 116-125).

21. In part, that evaluation stated:

> Information was obtained from father, stepmother, and [Petitioner] and a review of the record, including psychiatric evaluation done on 12/05/18. [Petitioner] has had a lot of behavior issues in the past year. For example, recently he used his walkie talkie to talk to a stranger and when parents tried to talk to him about this, he became argumentative and out of control, was screaming, running down the stairs and was verbally aggressive. Whenever he does something wrong, he does not want to talk about it and will not admit he did it. On several occasions, he has stolen items such as jewelry from his sisters and stepmother and he hides the objects in his room. He is sensitive to criticism and if confronted with his behavior, he will throw things, push a chair roughly, and knock things down. In August, 2020 he was stalking a 14-year-old girl, hanging out near her house even though she did not want him there. He was soiling his pants and then hiding the soiled underwear in his siblings' room. He stopped doing this in August after his third hospitalization. Parents state that [Petitioner] picks fights with everyone in the household and can't keep friends. Stepmother reports [Petitioner's] behavior escalates in June and November. [Petitioner] also has symptoms of ADHD. When he is not on his medication, he can't stay still and is bouncy and can't focus on his schoolwork. [Petitioner] was hospitalized at Harbor Oaks 3 times in the past year. Once, it was because a neurologist said he should be placed in a group home and [Petitioner] ran away and threatened suicide. Other times, it was for running away or out of control behavior. He also went to the Face to Face partial hospitalization program 5 times in the past year. His medications were changed often due to these multiple hospitalizations . . . Parents have also sent [Petitioner] to Boot Camp twice and they state this helped with his behavior. Parents state there is no concern for smoking, vaping, alcohol or substance abuse.

> There is no psychotic thinking. [Petitioner] denies depression or anxiety and denies suicidal thoughts. Last year, [Petitioner] was well behind in completing his schoolwork and resisted doing work. Currently, he is completing his schoolwork and getting A's and B's.

Exhibit A, page 116

22. On October 21, 2020, an Individual Plan of Service (IPOS) meeting was held with respect to Petitioner for his plan year October 21, 2020, through October 20, 2021. (Exhibit A, pages 104-115).

23. Petitioner, his parents and his therapist attended the meeting and contributed to the plan. (Exhibit A, page 104).

24. In part, the IPOS noted that Petitioner needed a lot of help with friendships, self-development, safety concerns, behaviors, and attitudes. (Exhibit A, page 107).

25. Goal #1 of the IPOS stated:

> Family/Emotional/Safety: [Petitioner] stated "I want to have less arguing. I will try not to freak out on everything they say." [Petitioner] stated he will learn at least 3-5 new skills over the next year. [Petitioner] will attend therapy at least 4 times per month. [Petitioner] will learn to manage strong emotions & make safe choices.

Exhibit A, page 108

26. Goal #2 of the IPOS stated:

> Health/Community: [Petitioner] stated "I feel fine" meeting with Linda Storey, PA. "It's helping." [Petitioner] will take his medication as prescribed. [Petitioner] will attend medication reviews at least bi-monthly. [Petitioner], dad &/or stepmom will provide input & feedback about progress with medication.

Exhibit A, page 110

27. On March 8, 2021, Petitioner's father called the police and requested that Petitioner be taken to Common Ground for a medication evaluation, with Petitioner eventually agreeing to go. (Exhibit A, pages 58-60).

28. On March 16, 2021, Petitioner's father called the police to report a "mental breakdown" for Petitioner and requesting that Petitioner be taken to Common Ground. (Exhibit A, pages 55-57).

29. The police subsequently noted that Petitioner's father had reported that Petitioner was talking out of turn, and that they advised Petitioner's father that Common Ground was a resource for help, not punishment. (Exhibit A, pages 55-57).

30. In April of 2021, Petitioner spend a weekend at a camp for a program called Individual Camper Experience (ICE), during which time he was disrespectful, defiant, and tried to elope. (Exhibit A, page 76).

31. That weekend was Petitioner's fourth time at ICE and, while previous times had shown better results, its Program Director subsequently recommended a long-term program for him. (Exhibit A, pages 77-82).

32. On May 19, 2021, Easterseals evaluated Petitioner and noted that he had been home for a week after being at Safehaus for three weeks due to suicidal thoughts. (Exhibit A, pages 159-167).

33. In June of 2021, Petitioner obtained a job at McDonald's. (Exhibit A, page 149).

34. However, on June 18, 2021, McDonald's reported to the police that Petitioner had stolen money from the register while working. (Exhibit A, pages 41-54)

35. Petitioner confessed and was subsequently charged, with the charge still pending. (Exhibit A, pages 41-54; Testimony of Petitioner's representative).

36. On July 19, 2021, Easterseals submitted a request to Respondent that Petitioner be admitted into a State psychiatric hospital on a long-term basis, along with documentation from Petitioner's record. (Exhibit A, pages 101-171).

37. As part of that request, Easterseals indicated that, on April 14, 2021, Petitioner has a Child and Adolescent Functional Assessment Scale (CAFAS) score of 180. (Exhibit A, page 101).

38. In response to a question of what would be needed for Petitioner to not be admitted to a State Facility, such as therapeutic foster care, 24 hours supports or ACT, Easterseals wrote:

> Parents want [Petitioner] to be safe in the home and in the community. They want him to refrain from physical aggression towards others, stealing and self-harming behaviors. They feel his behaviors put him at a high risk of continued involvement the juvenile system and/or hospitalizations.

Exhibit A, page 103

39. When asked for its recommendations, Easterseals wrote:

> There is discussion about possible [Fetal Alcohol Spectrum Disorder (FASD)] however there is no diagnosis on file at this time. Per clinician, [Petitioner] does present with symptoms of FASD and dad reports that mom used various drugs and alcohol whole pregnant.
> Due to this, the following is recommended by the ES Treatment Team.
> -Assessment for FASD
> -Refer to Families Moving Forward or Strengthening Families
> -Refer to MRT
> -Refer to Neurotesting
> -Refer to DBT
> -Refer to Trauma Workshop (ES)

Exhibit A, page 103

40. On July 21, 2021, a Wraparound Plan Meeting was held with respect to Petitioner. (Exhibit A, pages 168-171).

41. During that meeting, it was noted that Petitioner had been kicked out of Sanctuary two days prior due to his behavior; Petitioner's father was trying to find another program for Petitioner, but that his requests were denied because Petitioner had already failed at similar placements; and that Petitioner would be leaving for the Wilderness Program at Eagle Village in two days. (Exhibit A, page 168).

42. The Wraparound Meeting report also stated:

> Team talked about additional strategies that could be implemented to provide the family with further support, including an FASD evaluation for Strengths and Strategies (referral submitted, no open spaces right now), post adopt services (currently receiving), PMTO (referral submitted) or an FBA for a Behaviorist.

Exhibit A, page 169

43. That same day, Petitioner's father called the police after Petitioner came home with an electric scooter that Petitioner had stolen. (Exhibit A, pages 38-40).

44. On July 22, 2021, Respondent sent Petitioner's request for long-term hospitalization at a State psychiatric facility to Prest & Associates, LLC (Prest) for an independent review. (Exhibit A, pages 32-37).

45. That same day, Dr. Barbara Center, an M.D. certified in psychiatry by the American Board of Psychiatry and Neurology, who also has a Board Certification Specialty in Child/Adolescent Psychiatry, issued a report in which she stated in part:

> The patient is a [redacted]year-old mate. The patient's parents are concerned about the patient's behaviors, aggression, stealing, and self-harm behaviors. There are concerns that his ongoing behaviors have placed him at risk for continued involvement with the juvenile justice system or psychiatric hospitalization.
>
> Diagnoses include Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder, and Parent-Child Relational Problem. He does have a history of inpatient psychiatric hospitalization in April, 2021. He has had involvement with triage in March 2021 and April, 2021 and partial hospitalization in March 2021.
>
> There has been discussion about possible Fetal Alcohol Syndrome. The patient's father

> reports that the patient's mother used drugs and alcohol while pregnant.
>
> In the opinion of this reviewer, the patient does not meet medical necessity criteria for admission to a state facility as requested. There are less restrictive alternate levels of care available.

Exhibit A, page 33

46. On July 23, 2021, Respondent sent Petitioner's representative an Adverse Benefit Determination stating that the request for placement in a State Hospital had been denied. (Exhibit A, pages 24-27).

47. In part, that determination stated:

> The request for state facility admission is being denied. According to the MCG inpatient criteria for indications of admission to acute care/42 CFR 438.400 criteria and the information provided in the state facility application disposition this service is not medically necessary. This decision was based on the Michigan Medicaid Provider Manual and was made using PREST: Dr. Center's review of the information provided. There are no reports of active suicidal/homicidal ideation or command auditory/visual hallucinations. There is no evidence of being gravely disabled, severely disorganized, and/or unable to care for basic needs. No substance abuse symptoms that require inpatient treatment, no acute medical concerns requiring 24 hour a day, 7 day a week medical and nursing care.
>
> Alternate, less restrictive, interventions to state facility that may be considered include: Assessment for Fetal Alcohol Syndrome, referral to additional outpatient supports such as Families Moving Forward, Dialectical behavior therapy, trauma workshop, and neuropsychological testing could all be considered.

Exhibit A, pages 24-25

48. Petitioner's representative requested a second opinion with respect to that decision. (Exhibit A, page 28).

49. On July 27, 2021, Respondent sent that request to Prest for another independent review. (Exhibit A, pages 32-37).

50. That same day, Dr. Diana Antonacci, an M.D. certified in psychiatry by the American Board of Psychiatry and Neurology, who also has a Board Certification Specialty in Child/Adolescent Psychiatry, issued a report in which she stated in part:

> This is a [redacted]-year-old male with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, and Disruptive Mood Dysregulation Disorder. There is noted to be parent-child relational problems and high expressed emotions within the family. The patient is currently prescribed Depakote, Intuniv, and Lexapro. He has a history of partial hospitalization in March 2021. He was seen by triage on 03/29/21 and had an inpatient admission on 04/12/21. The patient was, again, seen by triage on 04/19/21 and was placed in sanctuary. He is currently receiving outpatient therapy, psychiatric services, wraparound services, SED labor services, respite/CLS services, and has a parent support partner and a use peer partner. The patient is homeschooled. He lives with his father and stepmother. He has 2 sisters. The family is concerned for the patient's safety in the home and community. He has a history of physical aggression, stealing, and self-harm behavior. The parents are concerned that the patient is at high risk for continued involvement in the Juvenile Justice System and/or hospitalization.
>
> In the opinion of this reviewer, medical necessity criteria for admission to a start psychiatric hospital is not met. The patient has no evidence of imminent dangerous to self or others. There is no suicidal or homicidal ideation or psychosis, severe mood symptoms or self-injurious behavior. There is not evidence that the patient cannot receive support and access to therapeutic services outside of an inpatient setting. There are no

> current symptoms or behaviors that require 24-hour a day, 7 day a week medical and nursing care. Less restrictive alternate levels of care are available.
>
> *Exhibit A, page 84*

51. On July 28, 2021, Respondent sent Petitioner's representative an Adverse Benefit Determination stating that the request for placement in a State Hospital remained denied. (Exhibit A, pages 28-31).

52. In part, that second Adverse Benefit Determination stated:

> The second opinion request for state facility admission is being denied. According to the MCG inpatient criteria for indications of admission to acute care/42 CFR 438.400 criteria and the information provided in the state facility application disposition this service is not medically necessary. This decision was based on the Michigan Medicaid Provider Manual and was made utilizing PREST: Dr. Antonacci's review of the information provided. There is no evidence of imminent danger to self or others. There is no suicidal or homicidal ideas or psychosis, or severe mood symptoms. There is no evidence that [Petitioner] can not receive support and access to therapeutic services outside of an inpatient setting or require 24 hour a day/7 day a week a week medical and nursing care.
>
> Alternate, less restrictive, interventions to state hospital that could be considered include: Assessment for fetal alcohol syndrome, referrals to family support services, trauma workshops, Dialectical Behavioral Therapy, and neuropsychological testing.
>
> *Exhibit A, pages 28-29*

53. On July 29, 2021, Petitioner's father filed a Local Appeal with Respondent regarding that decision. (Exhibit A, page 7).

54. That same day, Respondent's representative spoke with Petitioner's father, who indicated that Petitioner had run away from Eagle Village the night before; he was eventually located by a canine unit; and he was

currently being treated in urgent care for a twisted ankle. (Exhibit A, page 10).

55. On August 6, 2021, Petitioner's representative reported that Petitioner had been admitted to a residential program for youths following another incident over the weekend, where Petitioner had threatened his parents and eloped on foot. (Exhibit A, page 10).

56. On August 10, 2021, Respondent sent Petitioner's representative written notice that, following a review, the Adverse Benefit Determination was being upheld. (Exhibit A, pages 7-16).

57. That notice also identified who took part in the Local Appeal, including Petitioner's representative; the documents that were reviewed; and the applicable policies. (Exhibit A, pages 7-13).

58. On August 23, 2021, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed on Petitioner's behalf in this matter. (Exhibit A, pages 2-3).

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 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 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).

Here, as discussed above, Petitioner has been receiving services through the SEDW in the community while his representative has now requested a long-term hospitalization in a State psychiatric hospital for Petitioner.

With respect to inpatient psychiatric hospital admissions, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **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 MDHHS 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.

* * *

8.2 APPEALS

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

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

* * *

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.C. INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the child, youth, or young adult is displaying signs and symptoms

of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

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

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 disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care. ➢ Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others. ➢ Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction. ▪ Disruptions of Self-Care and Independent Functioning ➢ Beneficiary is unable to maintain adequate nutrition or self-care due to a severe psychiatric disorder.

	➢ The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance. ▪ Harm to Self ➢ A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity. ➢ There is a specific plan to harm self with clear intent and/or lethal potential. ➢ There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts. ➢ There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior. ➢ There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations. ➢ There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder. ▪ Harm to Others ➢ Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future. ➢ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.

	➢ There has been significant destructive behavior toward property that endangers others, such as setting fires. ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the 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 psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

	▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.D. INPATIENT PSYCHIATRIC CARE – CONTINUING STAY CRITERIA: ADULTS, ADOLESCENTS AND CHILDREN

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for

> continued stays that are due solely to placement problems or the unavailability of aftercare services.
>
> *MPM, July 1, 2021 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 59-67*

Additionally, with respect to the location and medical necessity of services, the MPM further states:

> **2.3 LOCATION OF SERVICE [CHANGES MADE 4/1/21]**
>
> 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.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. 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 home.
>
> * * *
>
> **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, 2021 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 10, 14-16
(Internal highlighting omitted)

Here, as discussed above, Respondent denied Petitioner's representative's request for long-term hospitalization in a State psychiatric hospital for Petitioner.

In support of the action, Respondent's representative described the procedural history of the case, including two separate reviews by Prest and a review by Respondent's Chief Medical Director finding in favor of the denial. She also testified that, whether or not it supports the request, Easterseals must submit the request for long-term

hospitalization if Petitioner's representative wanted it submitted and that, during the appeal process, Easterseals advised Respondent that it did not support the request.

Respondent's Manager of Utilization Management and Review testified that Easterseals submitted the request and documentation in this case, but she was not sure if Easterseals was recommending the placement and that it was not dispositive either way. She also testified that she twice forwarded the request to Prest, a credentialed agency that is contracted with Respondent, for independent reviews and that both reviews found that the request should be denied. She also testified about the local appeal subsequently completed by Respondent; its specific findings; and its conclusion that, at the time of the denial, services were authorized in a sufficient amount, scope and duration to meet Petitioner's needs. She further testified that Respondent will follow up with Easterseals will follow its recommendations.

Respondent's Chief Medical Director testified regarding his credentials, including board certifications in psychiatry and forensic psychology, and his role in the review of the local appeal in this case. He also described his findings following the review, including determinations that Petitioner's current supports are sufficient; that the severity of Petitioner's illness did not meet the applicable criteria for inpatient admission or treatment, with elopement being a rational planned response to a perceived lack of freedom and there being no disruptions of self-care or harm to self; and that the intensity of Petitioner's services likewise did not meet the applicable criteria either. He further discussed the difference between a long-term hospitalization and short-term, acute services, and why Petitioner did not meet the requirements for a long-term placement here.

In response, Petitioner's father and stepmother testified that the record in this case is inaccurate or incomplete and that Petitioner has been discharged from four 21-day programs within the past four months due to his behaviors; he has threated his family and the police on multiple occasions; they cannot find hospitals that will take Petitioner because of his violent behaviors; they have had to hide all the knives in the house; Petitioner has choked his sisters; and family members have heard him taking to people who are not there on multiple occasions.

They also testified that Petitioner has exhibited severe signs of mania that he will not remember afterward; the police have been called to the home nine or ten times; Petitioner is facing an embezzlement charge after stealing from his employer; he has stolen other things; and that they have found pictures of him on his computer where he was threatening to kill himself.

They further testified that Petitioner stole undergarments from his stepmother and sisters, defecated in them and built a shrine with them; no one feels safe in the house, even with the presence of cameras and sensors; he has threatened to kill others and himself; and he will become disconnected from reality and stare out of windows for thirty minutes at a time.

Petitioner's father and stepmother also testified that the application and documentation sent in by Easterseals for the long-term inpatient hospitalization did not present an accurate or complete picture of Petitioner's circumstances. They did testify that Easterseals supports the request at issue in this case.

They further testified that Petitioner's services include peer supports, wraparound services, therapy, parent supports and psychiatric services, but that Petitioner has not utilized CLS or respite because they cannot find a worker. They also testified that Petitioner recently completed a FASD assessment, with the assessment confirming the suspected diagnosis, but that they have not receive any services based on that assessment yet. They further testified that they have reached out to a behavioralist, but have not heard back yet.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for long-term hospitalization. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner, who has been approved for services through the SEDW, undisputedly has serious mental health diagnoses and significant behavioral issues and needs, but those diagnoses and issues alone are insufficient to warrant a long-term inpatient hospitalization and the record as a whole fails to reflect medical necessity for the request service.

The above policy expressly states both that Respondent is encouraged to provide mental health and developmental disabilities services in integrated locations in the community and that, using criteria for medical necessity, it may deny services for which there exists other appropriate, efficacious, less restrictive, and cost-effective services, settings or supports that otherwise satisfies the standards for medically necessary services; and, taking into account Petitioner's circumstances and the services available in the community, which by its nature is a less restrictive environment than the psychiatric hospital sought by Petitioner's representative, multiple psychiatrists have reviewed the request and found that it should be denied.

In particular, Respondent's Chief Medical Officer fully and credibly testified during the hearing regarding the basis for his determination, including his findings that neither the severity of Petitioner's illness nor the intensity of his services required an inpatient admission and how properly authorized services in the community could meet Petitioner's needs in a less restrictive environment.

Those services could include Petitioner's currently authorized services in the community, including some that have not yet been utilized, as well as services that had

been recommended, but not yet tried, at that the time of the decision in this case, including Trauma-Focused Cognitive Behavioral Therapy (TFCBT), treatment with a behaviorist, and an assessment and services for Fetal Alcohol Spectrum Disorder (FASD).

Moreover, contrary to what Petitioner's representative testified to during the hearing, it does not appear that even Easterseals, the agency providing Petitioner's services, supports the hospitalization as, rather than a hospitalization, its only specific recommendations in the application were for an assessment for FASD and referrals for other groups, testing and services.

According to Petitioner's representative, the assessment for FASD has now occurred and that the diagnosis has been confirmed, but that Petitioner has not yet received any additional services and that hospitalization is still needed. However, that assessment and any subsequent determinations are beyond the scope of this proceeding as the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information Respondent had at the time it made the decision.

Similarly, while Petitioner's parents testified regarding numerous issues that they believe were not reflected in the documentation submitted to Respondent along with the request or in Petitioner's electronic record, the undersigned Administrative Law Judge assigns some of that testimony little weight given that he is limited to reviewing Respondent's decision in light of the information Respondent had at the time it made the decision.

To the extent Petitioner's circumstances have changed or his representative has new, updated or additional information to provide, Petitioner's representative can always have a new request submitted along with that information. However, with respect to the issue in this case, the undersigned Administrative Law Judge finds that Respondent did not err given the information available at the time and that the denial must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for long-term hospitalization in a State psychiatric hospital.

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sb

Steven Kibit
Administrative Law Judge

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.

Benita Brown
Oakland Community Health Network
5505 Corporate Drive
Troy, MI 48098
dueprocess@oaklandchn.org

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI 48913
MDHHS-BHDDA-Hearing-Notices@michigan.gov

Authorized Hearing Rep.

[redacted]
MI

Petitioner

[redacted]
MI