STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[redacted]

Date Mailed: July 9, 2024
MOAHR Docket No.: 24-006364
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for a hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on July 3, 2024. [redacted], Petitioner's mother, appeared and testified on the minor Petitioner's behalf. George Motakis, Fair Hearing Officer, appeared and testified on behalf of Respondent Lakeshore Regional Entity (Respondent). Dominique Stevens, Clinician, and Angie Watkins, Access Center Director, from Network 180 also testified as witnesses for Respondent.

During the hearing, the following exhibits were admitted into the record without objection:

Exhibit A: Notice of Adverse Benefit Determination

Exhibit B: Excerpt from Medicaid Provider Manual

Exhibit C: Documentation from Forest View Hospital

Exhibit D: Request for Local Appeal

Exhibit E: Notice of Receipt of Local Appeal

Exhibit F: Notice of Appeal Denial

Exhibit G: Appeal Summary Report

Exhibit H: Request for Hearing

Exhibit I: Notice of Hearing

ISSUE

Did Respondent properly deny Petitioner's request for inpatient psychiatric hospitalization?

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 fifteen (15) year-old Medicaid beneficiary who has been diagnosed with, among other conditions, an eating disorder; generalized anxiety disorder; autism spectrum disorder; attention-deficit/hyperactivity disorder; obsessive-compulsive disorder; and post-traumatic stress disorder. (Exhibit A, pages 1, 19; Testimony of Petitioner's representative).

2. She has a history of inpatient hospitalizations. (Exhibit A, page 11; Testimony of Petitioner's representative).

3. She has also been screened and approved for services through Network 180, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP), pursuant to the Children With Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW). (Testimony of Respondent's representative; Testimony of Clinician).

4. On February 8, 2024, Petitioner presented at Helen DeVos Children's Hospital (HDVCH). (Exhibit A, page 11).

5. At that time, her mother requested that Petitioner be admitted inpatient through Network 180 and Respondent due to Petitioner's suicidal thoughts. (Exhibit A, page 12).

6. A Clinician with Network 180 assessed Petitioner that same day and determined that the request for inpatient hospitalization should be denied. (Exhibit A, pages 1-23; Testimony of Clinician).

7. On February 8, 2024, Network 180 also sent Petitioner a Notice of Adverse Benefit Determination stating that the request for inpatient hospitalization had been denied. (Exhibit A, pages 2-8).

8. In part, that notice provided:

> You do not meet the clinical eligibility criteria for services.

> Your request for inpatient hospitalization has been denied. At this time, there is no evidence an additional inpatient hospitalization will mitigate chronic symptoms of disordered eating and self-harm. Instead, the recommended level of care in Partial Hospitalization. An intake was scheduled for Monday, 2/12, at 8am at Forest View.
>
> The following criteria was used in your case, MCG Behavior Health Care (27th Edition) (B-901-IP), Inpatient Behavioral Health Level of Care, Child.

Exhibit A, page 2

9. Petitioner's representative requested a second opinion, and another assessment with Network 180 was scheduled for a few days later on February 12, 2024. (Testimony of Petitioner's representative; Testimony of Clinician).

10. However, after leaving HDVCH on February 8, 2024, Petitioner's behaviors escalated over that day and night and her passive thoughts regarding suicide became urges, with Petitioner having a definite and specific plan to commit suicide. (Testimony of Petitioner's representative).

11. Accordingly, on February 9, 2024, Petitioner's representative took her to Forest View Hospital and again requested an inpatient hospital admission. (Exhibit C, pages 1-7; Testimony of Petitioner's representative).

12. At Forest View Hospital, the medical team determined that Petitioner should be admitted as an inpatient in order to treat increased suicidal ideation, self-harm, and restrictive eating. (Exhibit C, page 7).

13. However, on that day, February 9, 2024, Network 180's Mobile Crisis Team denied Petitioner's request for inpatient hospitalization at Forest View Hospital. (Testimony of Petitioner's representative; Testimony of Clinician; Testimony of Access Center Director).

14. Network 180 issued a Notice of Adverse Benefit Determination with respect to that denial, but Petitioner's representative only received a verbal denial. (Testimony of Petitioner's representative; Testimony of Access Center Director).

15. Petitioner's representative subsequently filed a Local Appeal with Respondent. (Exhibit D, page 1; Exhibit E, pages 1-5).

16. In that request, she indicated that she was requesting a Local Appeal with respect to the February 9, 2024, notice and action. (Exhibit D, page 1).

17. She also wrote that she was requesting a Local Appeal for the following reason: "My daughter needs inpatient and was denied through N180." (Exhibit D, page 1).

18. In support of the Local Appeal, Forest View Hospital provided documentation regarding its decision to admit Petitioner as an inpatient. (Exhibit C, pages 1-7).

19. On February 28, 2024, Respondent sent Petitioner's representative a Notice of Appeal Denial. (Exhibit F, pages 1-6).

20. In that notice, Respondent stated that the Local Appeal was denied because:

> You would like your daughter to have inpatient hospitalization treatment. After reviewing the assessment [Petitioner] meets MCG criteria for partial hospitalization. She is not attempting to hurt herself during assessment period, was cooperative and noted inpatient hospitalization has not worked for her in the past. She has an appointment scheduled 2/12/2024.

Exhibit F, page 1

21. On June 10, 2024, MOAHR received the request for hearing filed in this matter with respect to that Notice of Appeal Denial and the decision to deny Petitioner's request for an inpatient hospitalization. (Exhibit H, pages 1-5).

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).

As discussed above, Petitioner is enrolled in the SEDW and receiving services through Respondent and its associated CMHSP Network 180. With respect to that program, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 1 – GENERAL INFORMATION**
>
> The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDHHS operates the SEDW through managed care contracts.
>
> **1.1 KEY PROVISIONS**
>
> The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.
>
> Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and their family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in an IPOS.
>
> A SEDW beneficiary must receive at least one SED waiver service per month in order to retain eligibility.
>
> * * *
>
> **SECTION 3 – MEDICAID STATE PLAN SERVICES**
>
> In addition to SEDW services, children served by the SEDW have access to Medicaid Mental Health State Plan services (e.g., psychotherapy, medication management, OT and PT evaluations, home based services). Services that can be billed to Medicaid are listed on the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database which is available on the MDHHS website.

The database lists the CPT/HCPCS code, modifiers (when applicable), short description, Medicaid fee screen, and applicable quantity/timeframe parameters for each service. (Refer to the Directory Appendix for website information.)

MPM, January 1, 2024
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages B1, B13

Among those State Plan services that can be received through the SEDW are inpatient psychiatric hospital services:

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 they reside. 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 their legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, they 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.
>
> *MPM, January 1, 2024*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 68-71*

While inpatient psychiatric hospitalizations are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

> **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, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15

Moreover, in making adverse benefit determinations regarding requested services a Managed Care Organization like Respondent is required to develop a grievance and appeal system pursuant to the applicable federal regulations:

Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

42 CFR 438.400(b)

(a) Notice. The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in § 438.10.

(b) Content of notice. The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other

information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) Timing of notice. The MCO, PIHP, or PAHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§ 431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1).

(4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with § 438.210(d)(1)(ii), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in § 438.210(d)(2).

42 CFR 438.404

(a) General requirements. In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) Special requirements. An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in § 438.408(b) and (c) in the case of expedited resolution.

(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in § 438.408(b) and (c).

(6) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

42 CFR 438.406

(a) Basic rule. Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) Specific timeframes—

(1) Standard resolution of grievances. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) Extension of timeframes.

(1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional

information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(3) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(d) Format of notice—

(1) Grievances. The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at § 438.10.

(2) Appeals.

(i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at § 438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) Requirements for State fair hearings—

(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) External medical review. The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(B) The review must be independent of both the State and MCO, PIHP, or PAHP.

(C) The review must be offered without any cost to the enrollee.

(D) The review must not extend any of the timeframes specified in § 438.408 and must not disrupt the continuation of benefits in § 438.420.

(2) State fair hearing. The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution to request a State fair hearing.

(3) Parties. The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

42 CFR 438.408

Here, pursuant to the above regulations, Respondent and Network 180 denied a request for an inpatient psychiatric hospitalization on February 8, 2024, and upheld that denial following a Local Appeal on February 24, 2024.

In support of those actions, a Clinician from Network 180 also testified with respect to her review of the request for admission to Helen DeVos Children's Hospital (HDVCH) on February 8, 2024, and why that request was denied, with the Notice of Appeal Denial later issued by Respondent echoing her findings.

However, both that Notice of Appeal Denial and Respondent's initial presentation during the hearing demonstrate that Respondent incorrectly identified the denial of inpatient psychiatric hospitalization at issue in the Local Appeal and Petitioner's request for hearing in this matter.

It is undisputed that, in addition to the denial of admission to HDVCH on February 8, 2024, Network 180 also denied an inpatient psychiatric hospitalization request from Petitioner for admission to Forest View Hospital on February 9, 2024.[1]

[1] The parties do dispute whether Network 180 issued a written denial of that request, but that dispute is ultimately irrelevant given that both sides agree that a denial was made.

Moreover, Petitioner's representative expressly stated in the Local Appeal form itself that she was requesting a Local Appeal with respect to the denial that occurred on February 9, 2024. Additionally, the documentation submitted in support of that Local Appeal all related to the need for admission at Forest View Hospital on February 9, 2024.

Similarly, Petitioner's representative's testimony during the hearing focused on the denial to admission to Forest View Hospital on February 9, 2024, with specific discussion of how Petitioner worsened between February 8, 2024 and February 9, 2024, including Petitioner developing a specific and detailed plan for suicide, and how the doctors at Forest View Hospital found that an inpatient psychiatric hospital was medically necessary.

Despite being the subject of the Local Appeal, Petitioner's evidence regarding the need for an inpatient psychiatric hospitalization, including reports of her worsening condition and the specific findings of doctors at Forest View Hospital, was never addressed by Respondent as required, with the Notice of Appeal Denial only referencing facts and circumstances related to the earlier denial and failing to discuss, or even acknowledge, the evidence submitted regarding the requested admission at Forest View Hospital.

Accordingly, Respondent erred in this case by misidentifying the decision at issue and failing to review and make an appeal decision as required on Petitioner's request for an inpatient psychiatric hospitalization to Forest View Hospital on February 9, 2024. As such, Respondent's decision must be reversed, and it must initiate the required assessment of Petitioner's request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for an inpatient psychiatric hospitalization to Forest View Hospital on February 9, 2024.

IT IS THEREFORE ORDERED that:

> Respondent's decision is **REVERSED,** and it must initiate a reassessment of Petitioner's request.

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 9th day of July 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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