



STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

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

MARLON BROWN
DIRECTOR

[REDACTED]
MI [REDACTED]

Date Mailed: January 8, 2025
MOAHR Docket No.: 24-011665
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, and following an adjournment granted at the request of the Respondent Detroit Wayne Integrated Health Network (Respondent), a telephone hearing was held on December 12, 2024.

Brendon Whitney, the Director of Utilization Management at [REDACTED] Center [REDACTED], appeared and testified on Petitioner's behalf. Alice Mason, Director of Clinical Services at Stonecrest, also testified as a witness for Petitioner.

Dorian Johnson, State Fair Hearing Officer, appeared and testified on Respondent's behalf. Dominique Johnson, a Utilization Management Administrator with Respondent, and Dr. Shama Faheem, Respondent's Chief Medical Officer, also testified as witnesses for Respondent.

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

Petitioner's Exhibits:

- Exhibit A: Medical Records, pages 1-15
- Exhibit B: Medical Records, pages 1-13
- Exhibit C: Medical Records, pages 1-185
- Exhibit D: Medical Records, pages 1-17

Exhibit E: Request for Hearing

Respondent's Exhibit:

Exhibit #1: Evidence Packet, pages 1-597

ISSUE

Did Respondent properly deny Petitioner's request for continued 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 [REDACTED] year-old Medicaid beneficiary who has been diagnosed with major depressive disorder, recurrent severe without psychotic symptoms, and post-traumatic stress disorder. (Exhibit D, pages 1-2)
2. She has a history of suicidal ideations/attempts and multiple inpatient psychiatric hospitalizations. (Exhibit #1, page 52; Exhibit B, page 4).
3. On August 14, 2024, Petitioner attempted to hang herself. (Exhibit B, page 4; Exhibit D, page 1).
4. That same day, Petitioner was admitted as an inpatient at [REDACTED] (Exhibit D, page 1).
5. The reason for the admission was subsequently identified as follows by Stonecrest:

[Petitioner] endorses depressed mood, crying, spells, initial, and middle insomnia. Energy levels can be high. Her focus concentration and attention is low. She endorses decreased appetite. When asked what triggered the suicidal thoughts she stated she had an argument with her mother. She states her mother is very mean to her and picks on her. She is always sending her to inpatient programs, but they never help.

Patient endorses increased anger agitation. She states she gets into fights. She was suspended from school this past year at the last two weeks of school because she was fighting for girls. She also was

banned from new Oakland because of fighting. When asked where the anger comes from she didn't know. She does have a history of self harm behavior in the past and stated that she was clean of cutting for a long time and then cut again recently. She states that she wants to change her fighting ways because she's going to start high school in the fall and wants to do better when asked she would achieve this she did not have any ideas.

* * *

She denies homicidal thoughts. She denies psychosis, mania, or hypomania. She denies hallucinations or delusions. She denies paranoid ideation. She denies a history of sexual physical or emotional abuse.

Exhibit D, page 1

6. Respondent initially approved the inpatient psychiatric hospitalization for the period of August 14, 2024 to August 17, 2024. (Exhibit #1, page 32).
7. Following reviews, Respondent subsequently approved the inpatient psychiatric hospitalization through August 21, 2024, and then through August 24, 2024. (Exhibit #1, pages 32, 34-51).
8. During her stay at [REDACTED] Petitioner received treatment from, and her case was overseen, by Dr. Preeti Venkataraman, a psychiatrist. (Exhibit C, pages 1-185).
9. Dr. Venkataraman was the physician who would make the determination for [REDACTED] as to when Petitioner was ready for discharge. (Testimony of [REDACTED] Director of Clinical Services).
10. On August 21, 2024, a social worker at [REDACTED] contacted Petitioner's mother to advise her that Petitioner would be discharged the next day as Petitioner was no longer a risk to herself or others and it was safe for her to return to the community. (Exhibit A, page 6).
11. In response, Petitioner's mother disagreed with the discharge and refused to pick Petitioner up upon discharge, while also stating that she wanted to rescind her parental rights. (Exhibit A, page 6).

12. During a conversation with the social worker on August 22, 2024, Petitioner's mother reported that there were no other family members who could take Petitioner home and that Petitioner's mother has filed a complaint with Child Protective Services (CPS). (Exhibit A, page 7).
13. Petitioner was upset about her mother refusing to pick her up, and she both got into verbal altercations with peers and was yelling and disrespectful to staff. (Exhibit C, pages 46, 51).
14. In an August 26, 2024, Psychiatry Progress Note, Dr. Venkataraman indicated the following with respect to Petitioner: "Treatment goals achieved and patient stable for discharge or step down". (Exhibit #1, page 428).
15. He also identified the reason for Petitioner's continued hospitalization as "Mother refuses to Pick [sic] her up". (Exhibit #1, page 428).
16. On August 26, 2024, [REDACTED] also submitted a request for continued inpatient psychiatric hospitalization for Petitioner. (Testimony of Respondent's Utilization Management Administrator).
17. That same day, Respondent completed a Continued Stay Review, in which it concluded that continued inpatient psychiatric hospitalization should be denied. (Exhibit #1, pages 25-33).
18. After being informed of that decision, [REDACTED] requested a second opinion. (Testimony of Petitioner's representative).
19. On August 27, 2024, Respondent submitted Petitioner's case and the request for continued inpatient psychiatric hospitalization to iMPROve Health for a Peer Review. (Exhibit #1, pages 22-24).
20. On August 28, 2024, Dr. Ashraf Ali, M.D., a psychiatrist with iMPROve Health, reviewed Petitioner's case and determined that Petitioner did not meet medical necessity for continued inpatient psychiatric hospitalization from August 25, 2024, and beyond. (Exhibit #1, pages 11-13).
21. His clinical rationale for that decision was:

[Petitioner] was no longer suicidal, homicidal, or gravely impaired for self-care. [Petitioner] had shown continued progress in treatment to a point that could have allowed her to be transitioned to a less restrictive level of care. [Petitioner] was not disturbed in thinking or behavior to require around the clock nursing supervision.

22. That same day, Respondent sent Petitioner a Letter of Adequate Notice of Adverse Benefit Determination stating that inpatient psychiatric hospitalization was denied as of August 25, 2024, because the clinical documentation provided did not establish medical necessity. (Exhibit #1, pages 14-21).
23. Petitioner and [REDACTED] did not request an Internal Appeal or a State fair hearing with respect to that decision upon receiving that notice or prior to Petitioner being discharged. (Testimony of Petitioner's representative).
24. As of August 28, 2024, Petitioner's mother was still refusing to pick Petitioner up upon discharge. (Exhibit A, page 11).
25. During late August and early September of 2024, Petitioner had instances of verbal aggression and physical aggression, including threats and attempted attacks on staff and peers, while hospitalized. (Exhibit C, pages 66-185).
26. On September 6, 2024, the social worker at [REDACTED] advised the CPS worker assigned to Petitioner's case that Petitioner has been eligible for discharge from Stonecrest since August 22, 2024. (Exhibit A, page 13).
27. On September 20, 2024, Petitioner was discharged from [REDACTED] (Exhibit D, pages 1-7).
28. She was discharged to her mother's care. (Exhibit D, page 1).
29. On September 30, 2024, [REDACTED] filed a standard appeal of the denial of the request for continued inpatient hospitalization, along with documentation supporting its appeal. (Exhibit #1, pages 52-581; Testimony of Petitioner's representative).
30. In part, that appeal stated:

During the denied dates of service, the patient's mother refused to take the child home and stated that she wanted to terminate her parental rights. Child Protective Services (CPS) was contacted and involved in the case through the duration of the stay. Beginning on 08/28/2024, the staff social worker continuously attempted to locate the CPS worker and was unsuccessful until 09/06/2024 when a supervisor was able to be reached. The supervisor reported that the assigned worker had been on vacation during this time period. At that time, the supervisor stated that she would be filing a petition to remove the child from her mother's care immediately. The supervisor

explained that after the petition was approved is when CPS could begin searching for foster home placement.

While working through this process, the patient's behavior continued to be impulsive and dangerous.

On the following dates, the patient was either physically aggressive or attempted to physically attack staff and/or peers: 8/27/24, 8/28/24, 8/29/24, 9/4/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, and 9/17/24.

On most days, the patient **was verbally aggressive and had instances of threatening peers and staff.** On 9/15/24, the patient broke a computer at the nurses' station.

The patient required **1:1 staffing from 9/6/24-9/6/24** due to aggression and inappropriate sexual behavior towards peers.

The patient was never able to understand or verbalize that her behavior was inappropriate.

* * *

We hope that in the attached documentation, you will agree that at no time prior to 9/20/24 was the patient able to be discharged due to continued dangerous behavior, as well as having no discharge placement options.

Exhibit #1, pages 52-53

31. Dr. Shama Faheem subsequently completed a physician consultation for Respondent with respect to the Internal Appeal, and she concluded that the denial should be upheld. (Exhibit #1, pages 582-589).

32. Regarding the clinical rationale for her decision, Dr. Faheem wrote:

Documents submitted with the appeal request were reviewed. It appears that during denied dates, patient reported no suicidal or homicidal ideations nor was observed harming self or others. She had an isolated incident with another patient on 9/3 which was thought to be related to her prolonged stay and stemming from her stressful relationship with mother

and her refusal to pick the patient from the unit. During the denied days, the psychiatrist has documented that patient did not have risk factors meeting inpatient level of symptoms, had met treatment goals and was ready for discharge with mother's refusal to pick her up, CPS involvement and placement being the reason for her stay. Therefore, I concur with initial denial because during the denied dates there is no documented risk of harm to self or others, nor the reported symptoms are severe enough to meet the most restricted level of care. The symptoms did not result in dysfunction that would require continuous observation and nursing care. Besides that, Medicaid Manual indicates that continued stay authorizations cannot be for placement purposes only and discharge planning should start at admission.

Exhibit #1, page 587

33. On October 17, 2024, Respondent sent written notice that the Internal Appeal had been denied because the clinical documentation provided did not establish medical necessity for the requested service. (Exhibit A, pages 590-597).
34. On October 23, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received a request for hearing filed in this matter regarding the decision to deny continued inpatient psychiatric hospitalization. (Exhibit E, pages 1-7).

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, Respondent denied Petitioner's request for continued inpatient psychiatric hospitalization as of August 25, 2024.

Regarding inpatient psychiatric hospitalizations, 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 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.

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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:

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| 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) | <p>At least one of the following manifestations is present:</p> <ul style="list-style-type: none"> • Severe Psychiatric Signs and Symptoms <ul style="list-style-type: none"> ➤ 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 |

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| | <p>living, so that the person cannot function at a lower level of care.</p> <ul style="list-style-type: none">➤ 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. <ul style="list-style-type: none">• Disruptions of Self-Care and Independent Functioning<ul style="list-style-type: none">➤ 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<ul style="list-style-type: none">➤ 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 |
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| | <p>threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.</p> <ul style="list-style-type: none">➤ 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. <ul style="list-style-type: none">● Harm to Others<ul style="list-style-type: none">➤ 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 |
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| | <p>therapeutic psychotropic medications.</p> <ul style="list-style-type: none"> • Drug/Medication Complications or Coexisting General Medical Condition Requiring Care <ul style="list-style-type: none"> ➤ 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. <p>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.</p> |
| <p>Intensity of Service</p> | <p>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:</p> |

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| | <ul style="list-style-type: none">• 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. |
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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.

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

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

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| Diagnosis | The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review. |
| Severity of Illness (signs, symptoms, functional impairments and risk potential) | <ul style="list-style-type: none"> • Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. • Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment. • Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment. • Continued significant self/other harm |

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| | <p>risk.</p> <ul style="list-style-type: none">• Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring.• Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria. |
| Intensity of Service | <ul style="list-style-type: none">• The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications.• The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.• Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.• The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment. |

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Discharge criteria and aftercare planning are documented in the beneficiary's record.

*MPM, July 1, 2024
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 69-78*

While inpatient psychiatric hospitalizations may be 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, July 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15*

Here, pursuant to the above policies, Respondent denied Petitioner's request for continued inpatient psychiatric hospitalization as of August 25, 2024.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ 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 ALJ finds that Petitioner has failed to meet her burden of proof; and that Respondent's decision must therefore be affirmed.

Petitioner's witnesses from [REDACTED] assert that Petitioner was never sufficiently stable to be discharged prior to September 19, 2024, but that testimony is directly contradicted by Petitioner's own records and completely unpersuasive. For example, Progress Notes from a [REDACTED] social worker indicate that [REDACTED] planned to discharge Petitioner as early as August 22, 2024, but that Petitioner's mother refused to pick her up. Moreover, a Psychiatry Progress Note completed by Petitioner's physician with respect to Petitioner on August 26, 2024, expressly stated that "[t]reatment goals achieved and patient stable for discharge or step down" and that the only reason for Petitioner's continued hospitalization was that Petitioner's mother refuses to pick Petitioner up.

Based on Stonecrest records, reviewers from Respondent and iMPROve Health also found that the request for continued inpatient psychiatric hospitalization should be denied, with the psychiatrist from iMPROve Health credibly and fully explaining his reasoning in writing.

Moreover, to the extent Petitioner's representative pointed to evidence of Petitioner's regression and instability after the decision was made in this case, behavior that most likely occurred in response to Petitioner's mother refusing to pick Petitioner up, that evidence is likewise unpersuasive given that it occurred after the decision at issue and the undersigned ALJ is limited to reviewing Respondent's decision in light of the information it had at the time it made the decision. Petitioner and ██████████ could have, but did not, seek a new admission based on that new information and it is therefore beyond the scope of this proceeding.

Accordingly, given the clear documentation from ██████████ and credible findings of multiple reviewers, the undersigned ALJ finds that Petitioner has failed to demonstrate any error in this case and that Respondent's decision to deny continued inpatient psychiatric hospitalization as of August 25, 2024, must be affirmed.

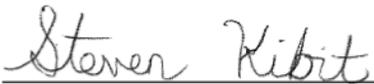
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for continued inpatient psychiatric hospitalization.

IT IS THEREFORE ORDERED that:

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

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 8th day of January 2025.



S. James

**Michigan Office of Administrative
Hearings and Rules**

Via Electronic Mail:

DHHS Department Contact

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Via First Class & Electronic Mail:

Petitioner

[REDACTED]

[REDACTED] MI [REDACTED]

[REDACTED]

Authorized Hearing Representative

[REDACTED]

[REDACTED] Center

[REDACTED]

[REDACTED] MI [REDACTED]

[REDACTED]