Date Mailed: March 2, 2026
Docket No.: 26-000448
Case No.: [redacted]
Petitioner: [redacted]

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 by Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on February 5, 2026. Bethany Viall from Utilization Review at Kalamazoo Behavioral Health Hospital, appeared and testified on Petitioner's behalf. Heather Woods, Fair Hearings Officer, appeared on behalf of Respondent Southwest Michigan Behavioral Health (Respondent). Katie Drenth, Utilization Reviewer; and Dr. Michael Redinger, Medical Director, testified as witnesses for Respondent.

During the hearing, Petitioner's request for hearing was admitted into the record without objection as Exhibit #1, pages 1-9. Respondent also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-25,

ISSUE

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

FINDINGS OF FACT

The ALJ, 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, among other conditions, bipolar disorder, schizophrenia, anxiety, depression, and cocaine dependence. (Exhibit A, page 12).

2. On [redacted] 2025, Petitioner was admitted to inpatient psychiatric care at Kalamazoo Behavioral Health Hospital. (Exhibit A, pages 4, 16).

3. He had no past history of past psychiatric hospitalizations or suicide attempts. (Exhibit A, page 12).

4. He was admitted for stabilization of his bipolar disorder accompanied by psychotic features. (Exhibit A, page 16).

5. Respondent approved inpatient psychiatric hospitalization through [redacted] 2025. (Testimony of Utilization Reviewer).

6. After thirty days of inpatient admission, Respondent initiated a routine review of Petitioner's inpatient admission. (Testimony of Utilization Reviewer).

7. In doing so, its Utilization Reviewer gathered clinical documentation from Kalamazoo Behavioral Health and spoke with Petitioner's representative. (Testimony of Utilization Reviewer).

8. Kalamazoo Behavioral Health Hospital continued to request inpatient psychiatric services for Petitioner, with no specific discharge date identified. (Exhibit A, pages 5-6).

9. On October 29, 2025, Respondent's Medical Director conducted a review of the request and hospital clinical records. (Exhibit A, pages 3-7).

10. In that review, the Medical Director determined that Petitioner did not meet the medical necessity criteria for a continued stay given Petitioner's stabilization and adequate functional status; the lack of any need for close observation; a completed medication review, with no further recommendations for inpatient care noted; and the completed clinical management and psychoeducation. (Exhibit A, page 7).

11. He did note that Petitioner was exhibiting symptoms of akathisia, as well as anger, verbal aggression and irritability, but also found that further hospitalization would only worsen those issues given Petitioner's multiple medications and desire to leave the hospital. (Exhibit A, page 4).

12. He did not reach out to anyone at Kalamazoo Behavioral Health Hospital regarding his concerns regarding Petitioner's care. (Testimony of Medical Director).

13. Respondent then denied in part the request for continued inpatient psychiatric hospitalization, with two additional days approved to assist with shelter placement as Petitioner was refusing to return to his previous Adult Foster Care (AFC) home. (Exhibit A, pages 3-7).

14. Kalamazoo Behavioral Health Hospital was made aware of the denial, but Petitioner remained in the hospital. (Testimony of Utilization Reviewer).

15. Petitioner continued to be irritable, quick to anger and frustrated with the hospitalization over the next few days. (Testimony of Petitioner's representative).

16. Some psychotropic medications were also titrated. (Testimony of Petitioner's representative).

17. On November 2, 2025, Petitioner demonstrated improvement in his mood and behavior. (Testimony of Petitioner's representative).

18. On [redacted] 2025, Petitioner was discharged from the hospital. (Exhibit A, page 12).

19. At the time of discharge, the Discharge Summary stated in part:

> [Petitioner's] Admission factors were reviewed during their hospitalization, Pt started to gradually improve, his mood gradually improved and symptoms improved. He was started on Current Psychiatric Medications . . . Haldol to 10 mg po am, 5 mg po at his mood- increased on 10/30/25 Pt's affect got better, and he became much more redirectable. Pt tolerated the medications well and denied SE to meds. Pt started to attend therapy, including individual and group therapy. Pt was seen at discharge and denied SI/HI. Was able to contract for safety. Pt is at risk for worsening symptoms and without treatment and we discussed a safety plan, emergency procedures, Medications risks and SE were also discussed.
>
> *Exhibit A, page 13*

20. On November 4, 2025, Respondent issued a written Notice of Adverse Benefit Determination. (Exhibit A, pages 8-10).

21. In part, that notice stated:

> **This is to tell you about our decision:**
>
> Kalamazoo Behavioral Health Hospital (provider) asked for approval of more inpatient mental health care for you. This request was denied on October 29, 2025 by Dr. Michael Redinger, our medical director. The last covered day was [redacted] 2025.
>
> **This decision is based on the following:**
>
> You did not meet the medical need for this case based on the Milliman Care Guidelines.
>
> We had approved 2 extra days already to help with placement concerns. There were concerns that staying in the hospital has made your mood less stable. It does not appear that you would benefit from

> further hospital care at this time. You are not at high risk of harming yourself or others. You have outpatient care available. You can monitor your mental health symptoms. You can make a crisis plan. You no longer need inpatient care to meet your mental health needs.
>
> *Exhibit A, page 8*

22. On November 12, 2025, Petitioner's representative/provider filed a Standard Appeal with Respondent. (Exhibit #1, page 6).

23. As part of that appeal, Petitioner's representative included clinical documentation regarding the treatment provided after Respondent denied further inpatient services. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

24. The appeal was then reviewed by a doctor at PREST and Associates, an external review agency that Respondent contracts with. (Exhibit A, pages 16-18).

25. On November 20, 2025, Respondent sent Petitioner, in care of Petitioner's representative, a Letter of Appeal Denial. (Exhibit #1, pages 6-9).

26. In that notice, Respondent stated that the appeal was denied because:

> You did not meet the medical need to keep this care based on the Milliman Care Guidelines.
>
> You did not show risk of harming yourself. You seemed to be at baseline. You did not need any more medication changes. You did not need 24-hour monitoring for health. You have outpatient care available to help you. You can make a safety plan. Placement seems to have been the main barrier to you leaving the hospital. Your mental health could be safely met at a lower level of care.
>
> *Exhibit #1, page 6*

27. On January 2, 2026, MOAHR received the request for hearing filed in this matter with respect to that decision. (Exhibit #1, pages 1-9).

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, the issue in dispute in this case involves Respondent's denial of continued inpatient psychiatric services for Petitioner after [redacted] 2025, with Petitioner subsequently discharged on [redacted] 2025, and Petitioner and his provider seeking payment for the noncovered days.

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 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.

* * *

8.5.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:

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,	▪ Persistence/intensification of signs/symptoms, impairments,

functional impairments and risk potential)	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 risk. ▪ 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	▪ 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.

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

MPM, October 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter,
pages 69, 76-78

Moreover, regarding appeals of authorization decisions, the MPM provides:

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.
>
> *MPM, October 1, 2025 version*
> *Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter,*
> *Page 70*

Here, Respondent denied continued inpatient psychiatric services after [redacted], 2025, pursuant to the above policies,

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned ALJ is limited to reviewing the Department's decision in light of the information it had at the time it made the decision.

Given the available information and applicable policies in this case, Petitioner has failed to meet his burden of proof; and the Department's decision must be affirmed.

The clinical documentation in the record is rather limited in this case, but it and the testimony of Respondent's witnesses, particularly its Medical Director, credibly explained why further inpatient psychiatric services were no longer medically necessary after [redacted] 2025.

Specifically, they provide that Petitioner had stabilized and was no longer at imminent risk of causing harm to others or himself, with no thoughts of suicidal or homicidal ideations; he did not require medication changes or around-the-clock monitoring; and his needs could be met with outpatient care. Petitioner's symptoms did not continue to be of such a nature and severity that inpatient psychiatric treatment was still medically necessary.

Moreover, Respondent's evidence also credibly provided that Petitioner's main barrier to discharge appeared to be issues with placement, as opposed to medical necessity, and, while Respondent did authorize two additional days to assist with placement, the above Section 8.5.D. of the above policy expressly provides that payment "cannot be

authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services".

Rather than directly disputing Respondent's decision on October 29, 2025, Petitioner's representative instead argued that Respondent erred by not conducting a peer-to-peer review or considering the additional documentation provided after Respondent's initial decision that demonstrated medical necessity for continuing inpatient psychiatric services.

However, neither argument is persuasive in this case, especially given Respondent's credible findings.

It is undisputed that no peer-to-peer review was requested in this case, and Petitioner fails to point to any requirement that one must be unilaterally initiated by Respondent. Moreover, while Petitioner's representative points to Respondent's Medical Director's concerns about possible negative effects of continuing inpatient care as a reason for such a review, the Medical Director testified that he did not believe one was necessary even considering those concerns and that testimony is credible given the finding that Respondent was already denying further inpatient services.

Additionally, while Respondent could not consider any additional documentation in making the initial decision in this case, because the documentation did not exist yet, it is undisputed that it was included as part of Respondent's appeal process. Regardless, the additional documentation was not submitted by Petitioner in this case and Petitioner relies solely on his representative's testimony; and, even accepting Petitioner's representative's testimony regarding what the documentation contained as true, Petitioner did not identify a significant conflict with what Respondent found or demonstrate a need for continued inpatient services. Everyone agreed that Petitioner was displaying irritability, anger, and frustration at the time of the denial and thereafter; but the record does not reflect, and Petitioner's representative did not demonstrate, that such behaviors necessitated an inpatient level of care. Similarly, with respect to Petitioner's medications, the identified management of those medications does not reflect a severity of illness or require the intensity of service that would warrant continuing inpatient admission.

Accordingly, for the reasons discussed above, Petitioner has failed to meet his burden of proof and Respondent's decision 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 services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

STEVEN KIBIT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to MOAHR-BSD-Support@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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