STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],
Appellant
_____/

Docket No. 2010-2704 QHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. [redacted], represented the Medicaid Health Plan (MHP), [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant coverage of counseling services in excess of 20 outpatient visits?

FINDINGS OF FACT

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

1. The Appellant is Medicaid eligible and is subject to the Medicaid managed care program and to program conditions.

2. The Appellant was enrolled in the [redacted] in [redacted] and is currently enrolled.

3. The Appellant is a [redacted] boy with a history of developmental delay. (Exhibit 2).

4. The MHP mental health benefits policy is consistent with Medicaid policy and has a limitation of 20 mental health visits per calendar year. (Exhibit 1, pp 7, 10, 15).

5. Between [redacted], the Appellant had twenty mental health outpatient counseling sessions covered by the MHP. (Exhibit 1, p 5).

6. On [redacted], the Appellant was sent a notice from the MHP informing him that he had reached his 20 mental health visit maximum for [redacted]. The notice enclosed a copy of his certificate of coverage which indicated that he may be eligible for additional mental health services through the local community mental health organization. (Exhibit 1, p 10).

7. The local community mental health organization in Appellant's area is called [redacted].

8. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's request for an administrative hearing. (Exhibit 2).

CONCLUSIONS OF LAW

The Medical Assistance Program 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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, FY 2008, p. 32.*

The MHP representative stated that the Appellant reached his yearly benefit maximum of 20 mental health visits and that is why the MHP could not provide coverage for

further mental health visits in [redacted]. The MHP representative introduced evidence that its policy is consistent with Medicaid policy.

The Appellant's representative/mother said the Appellant liked his current therapist. The Appellant's representative/mother said that she did not believe Appellant had ever received services from a local community mental health (CMH) and that she had never heard of [redacted].

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6* makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid outpatient mental health benefits. The Medicaid Provider Manual sets out the eligibility requirements as:

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
□ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. □ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	□ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). □ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. □ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not

	necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, July 1, 2009, page 3. (Underline added).

A review of the MHP's policy, its denial of mental health visits after it had already covered 20 visits in [redacted], and the Medicaid policy demonstrates that the MHP is only contractually obligated to provide coverage for 20 mental health visits per calendar year. Accordingly, the denial of Appellant's counseling services in excess of 20 outpatient visits was proper and in accordance with Department Medicaid policy. It was discussed with Appellant's mother that if Appellant is in need of more than 20 visits per calendar year he may seek eligibility for those additional mental health visits by contacting [redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied Appellant coverage for counseling services in excess of 20 outpatient visits.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/13/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.