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. 2010-3171 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 [redacted]. [redacted], represented the Appellant. [redacted], represented the Medicaid Health Plan (MHP).

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for additional outpatient mental health 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 a [redacted] Medicaid beneficiary who was enrolled in [redacted] MHP at all times relevant to this matter.

2. The Appellant requires mental health treatment.

3. The Appellant has participated in mental health treatment during the [redacted] calendar year. She has had at least 20 outpatient mental health visits covered by the Respondent health plan.

4. The Appellant's mother has changed her daughter's mental health provider and sought prior authorization for continued mental health

treatment services through the new provider.

5. The Appellant was notified on [redacted], that coverage for continuing mental health treatment services would not be authorized until the next calendar year, due to coverage limitations of 20 visits per calendar year.

6. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for an Administrative Hearing.

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 only 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. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.

The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, November 8, 2006.

The Contractor shall provide a maximum of 20 outpatient mental health visits within a calendar year consistent with the policy and procedures established by Medicaid policy. Services may be provided through contracts with Community Mental Health Services Programs (CMHSP), Pre-paid Inpatient Hospital Plans (PIHPs), or through contracts with other appropriate providers within the service area.

Article II-H, Utilization Management, Contract, November 8, 2006.

According to the MHP's Certificate of Coverage guidelines, [redacted] covers up to 20 outpatient mental health visits per year. (Department Exhibit A, page 7) The MHP's policy on outpatient mental health visits is consistent with the Medicaid policy. Medicaid policy does not provide coverage for mental health services in excess of 20 outpatient

mental health visits each contract year. (*DCH Medicaid Provider Manual, General Information for Providers, section 9.7, October 1, 2007)*

In this case, the Appellant is protesting the MHP's denial of her request for continued coverage of outpatient mental health treatment. It was asserted that due to a change in provider, it was believed, or assumed, that the 20 visit limit would start again. It was further asserted the Appellant's mother was never notified that her 20 visits were close about to be used in their entirety. She asserted she should have been notified of how many visits she had left before they were gone and she incurred a bill. She was informed that unless she had explicitly agreed to pay for treatment not covered as a Medicaid covered service, her provider was not allowed to bill her for a Medicaid covered service.

The MHP established that Appellant had already received coverage for 20 outpatient mental health visits in [redacted], and she had reached her outpatient visit limit. Again, the Medicaid policy does not require the MHP's to provide coverage for more than 20 outpatient mental health visits per calendar year. Should the Appellant require treatment in excess of 20 visits per year, she can contact Community Mental Health for assistance in getting the additional mental health treatment she may need.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Medicaid Health Plan properly denied the Appellant's request for additional outpatient mental health visits.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/5/2010

***** 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.